

10694

CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Spring Hill Private Sanitarium | | d. STREET ADDRESS R.D.# Merritt Mill Road | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First MINNIE Middle LEE Last ADAMS | | 4. DATE OF DEATH Month SEPT. Day 4th Year 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 28, 1883 |
| 9. AGE (In years last birthday) 75 yrs. | | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) None - House Work | | 10b. KIND OF BUSINESS OR INDUSTRY at Home | |
| 11. BIRTHPLACE (State or foreign country) Virginia | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Alfred Tenche | | 14. MOTHER'S MAIDEN NAME Hildred Seward | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mrs. Jessie A. Burns (Daughter) | | 18. ADDRESS R.D.# Merritt Mill Road - Salisbury, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio-Vascular Renal Disease DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from May 1957 to Aug. 4, 1958 , that I last saw the deceased alive on Aug. 2, 1958 , and that death occurred at 2:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sept. 5 / 58 | | | |
| ACTUAL SIGNATURE Philip A. Insley M.D. | | PHYSICIAN'S NAME (Type) Dr. Philip A. Insley Main St. Salisbury, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Sept. 7, 1958 | 22c. NAME OF CEMETERY OR CREMATORY St. Johns Church Cemetery | 22d. LOCATION (City, town, or county) (State) Powellville, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND | | 24a. REC'D BY REGISTRAR SEP 8 '58 | 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

County of ... State of ...

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FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10687

10738

Reg. Dist. No.

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|---|------------------------------|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar | | c. LENGTH OF STAY IN 1b X | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 607 Chestnut St. | | | e. STREET ADDRESS 607 Chestnut St. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) Rodney Dean Austin | | | 4. DATE OF DEATH Month 9 Day 30 Year 19 58 | | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 6-11-58 | | 9. AGE (In years last birthday) yrs. 3 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) infant | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) Salisbury, Md. | |
| 12. CITIZEN OF WHAT COUNTRY? U S A | | | 13. FATHER'S NAME James R. Austin | | |
| 14. MOTHER'S MAIDEN NAME Cecelia Mutchler | | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | |
| 16. SOCIAL SECURITY NO. None | | | 17. INFORMANT James Austin, Delmar, Md. | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Interstitial pneumonia 525x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ | | | | | INTERVAL BETWEEN ONSET AND DEATH hours. |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | |
| 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE Earl L. Royer | | M.D. Earl L. Royer, M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| EXAMINER'S NAME (Type) Earl L. Royer, M.D. | | DATE SIGNED 10-2-58 | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 10-1-58 | | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olive | |
| 22d. LOCATION (City, town, or county) Delmar, Del. | | 22e. (State) Del. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE W S Marvel and Co. Delmar, Del. | | ADDRESS | | 24a. REC'D BY REGISTRAR OCT 6 '58 DATE | |
| 24b. REGISTRAR'S SIGNATURE Arthur L. Kross | | | | | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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SEE PAGE
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11338

NAVY AND MARINE CORPS DEPARTMENT OF HEALTH - BUREAU OF
MEDICAL EXAMINERS' CLINICAL RECORDS

| | | | |
|----------------------|--|-------------------------|--|
| PATIENT'S NAME | | LAST FIRST MIDDLE | |
| DATE OF BIRTH | | MONTH DAY YEAR | |
| PLACE OF BIRTH | | CITY STATE COUNTRY | |
| RACE | | COLOR | |
| RELIGION | | MARRIAGE | |
| EDUCATION | | OCCUPATION | |
| PREVIOUS SERVICE | | REMARKS | |
| PHYSICAL EXAMINATION | | LABORATORY EXAMINATIONS | |
| X-RAY EXAMINATIONS | | HISTORICAL DATA | |
| TREATMENT | | PROGNOSIS | |
| DISPOSITION | | FOLLOW-UP | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10739

CERTIFICATE OF DEATH

10688

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Wicomico</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Fruitland</u> | | c. LENGTH OF STAY IN 1b <u>7 yrs.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Della Katherine Baker</u> | | 4. DATE OF DEATH <u>Sept. 17</u> 19 <u>58</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 16, 1879</u> |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Simp Hall</u> | | 14. MOTHER'S MAIDEN NAME <u>D. Hall</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Della Mae Darby</u> Address <u>Salisbury, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>434.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>260x Diabetes mellitus</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 wks</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>June</u> 19 <u>58</u> , to <u>death</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-17-58</u> , 19 <u>58</u> , and that death occurred at <u>5:15 P.</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Lee Lawry</u> | | ADDRESS (Street, city or town, state) <u>Fruitland Md</u> DATE SIGNED <u>9-18-58</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, or REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Sept. 21, 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Greenbrier</u> | | 22d. LOCATION (City, town, or county) (State) <u>(near Salisbury) Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> ADDRESS <u>Pocomoke City, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>SEP 23 '58</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knapp</u> | |

10695

CERTIFICATE OF DEATH

Reg. Dist. No.

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| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | | c. LENGTH OF STAY IN 1b 8 days | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Sarah Middle Shepherd Last Banks | | | | 4. DATE OF DEATH Month September Day 9 Year 19 58 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 12, 1888 | 9. AGE (In years last birthday) yrs. 70 | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Tennessee | |
| 13. FATHER'S NAME Thomas Walker Shepherd | | | | 14. MOTHER'S MAIDEN NAME Johnny Mae Graham | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk | | | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Hospital Records, Salisbury, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial insufficiency DUE TO 592X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Uremia DUE TO (c) Chronic glomerulonephritis | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6 hours Months Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from September 1 19 58 to September 9 19 58 ; that I last saw the deceased alive on September 8 , 19 58 , and that death occurred at 1:25A M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE L. V. Maldve | | | | ADDRESS (Street, city or town, state) Deer's Head State Hospital | | DATE SIGNED 9/9/58 | |
| PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. | | | | Salisbury, Maryland | | | |
| 22a. BURIAL, CREMATION, REMOVAL Burial | | 22b. DATE THEREOF 9/13/58 | | 22c. NAME OF CEMETERY OR CREMATORY Memorial Park | | 22d. LOCATION (City, town, or county) (State) Memphis, Tenn. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson Co. Salisbury, Maryland | | | | 24a. REC'D BY REGISTRAR SEP 15 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Hume | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

1900

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|-------------------|--|--------------|--|--------------|--|---------------|--|----------------|--|-----------------|--|------------------------|--|-------------------|--|------------------------|--|----------------------|--|------------------------|--|------------------------|--|
| Name of Deceased | | Sex | | Age | | Date of Birth | | Place of Birth | | Usual Residence | | Cause of Death | | Date of Death | | Place of Death | | Time of Death | | Signature of Physician | | Signature of Registrar | |
| John Doe | | Male | | 45 | | Jan 1, 1855 | | Maryland | | Baltimore | | Heart Disease | | Jan 15, 1900 | | Baltimore | | 5:00 PM | | J. B. Smith | | A. C. Jones | |
| Name of Informant | | Relationship | | Address | | City | | State | | County | | Signature of Informant | | Date of Statement | | Signature of Registrar | | Date of Registration | | Signature of Registrar | | Date of Registration | |
| John Doe | | Son | | 1234 Main St | | Baltimore | | Maryland | | Baltimore | | J. B. Smith | | Jan 15, 1900 | | A. C. Jones | | Jan 15, 1900 | | A. C. Jones | | Jan 15, 1900 | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10696

CERTIFICATE OF DEATH

10690
Reg. Dist. No.

| | | | |
|--|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN It <u>12</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>82 Peninsula General Hospital</u> | | d. STREET ADDRESS <u>Sheldon Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>DEBBIE LEE Bell</u> | | 4. DATE OF DEATH Month Day Year <u>September 10 - 1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> <u>BABY</u> | 8. DATE OF BIRTH <u>11:28 A.M.</u> <u>September 8 - 1958</u> |
| 9. AGE (In years last birthday) <u>0</u> yrs. <u>0</u> Months <u>2</u> Days | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>None</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Salisbury, Md. (Hospital)</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>Paul Bryan Bell</u> | | 14. MOTHER'S MAIDEN NAME <u>Lillie Mae Goslee</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>None</u> | |
| 17. INFORMANT <u>Mr. Paul Bryan Bell (Father)</u> | | Address <u>Sheldon Ave. Salisbury, Maryland</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Alelectasis</u> <u>762.5</u> DUE TO (b) <u>Prematurity (Birth wt 1290 Gms.)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <u>approx 4 hrs</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept 8, 1958</u> , to <u>Sept 10, 1958</u> , that I last saw the deceased alive on <u>Sept 10, 1958</u> , and that death occurred at <u>3:45 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Medical Center Salisbury, Maryland</u> | | | |
| ACTUAL SIGNATURE <u>Alfred C. Kolls</u> | | DATE SIGNED <u>9/10/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Dr. Alfred C. Kolls</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Sept. 11/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Wicomico Memorial Park</u> | | 22d. LOCATION (City, town, or county) (State) <u>Salisbury, Maryland</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> | | ADDRESS <u>SALISBURY MARYLAND</u> | |
| 24a. RECEIVED BY REGISTRAR <u>SEP 15 58</u> | | DATE <u>DATE</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Frank</u> | | | |

2082221 XVI

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 28 CERTIFICATE OF DEATH

10-22-28

NAME OF DECEASED
 A. S. JONES

DATE OF DEATH
 10-22-28

PLACE OF DEATH
 HOME

AGE
 65

SEX
 MALE

CAUSE OF DEATH
 HEART DISEASE

PLACE OF BIRTH
 MARYLAND

DATE OF BIRTH
 10-22-28

TIME OF DEATH
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TIME OF DEATH
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

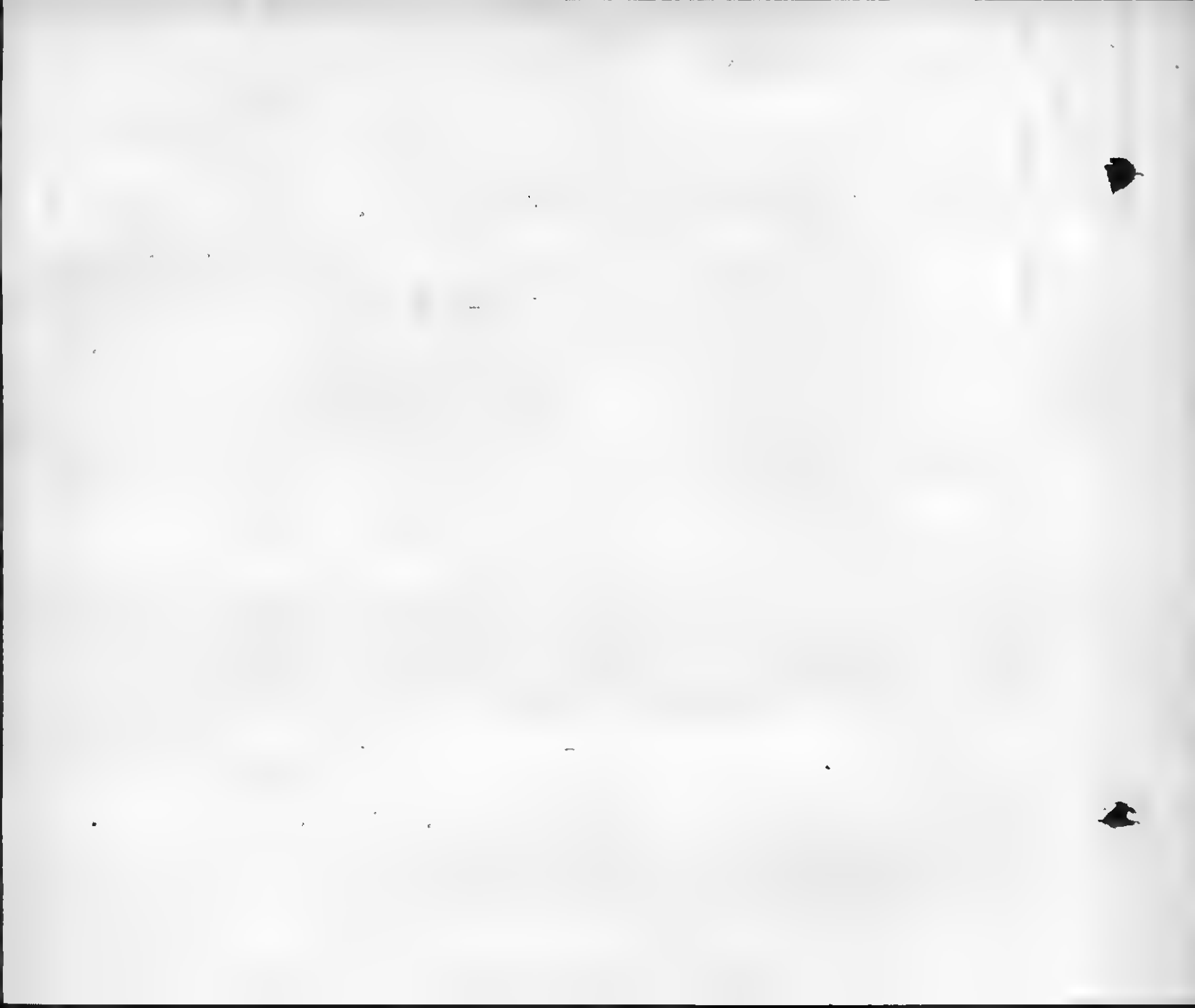
10697

CERTIFICATE OF DEATH

10691

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> | |
| c. LENGTH OF STAY IN 1b <u>2 1/2 Mo.</u> | | d. STREET ADDRESS <u>507 Market St.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springhill Sanitarium</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Frederick L. Bonneville</u> | | 4. DATE OF DEATH Month Day Year <u>Sept. 26, 19 58</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>12-2-1872</u> |
| 9. AGE (In years last birthday) <u>85</u> yrs | | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Hotel</u> | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> |
| 12. CITIZEN OF WHAT COUNTRY <u>U. S. A.</u> | | 13. FATHER'S NAME <u>T. Frank Bonneville</u> | |
| 14. MOTHER'S MAIDEN NAME <u>Elizabeth Veasey</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>No</u> | |
| 16. SOCIAL SECURITY NO. <u>None</u> | | 17. INFORMANT Address <u>J. C. Stevenson, Pocomoke City, Maryland</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiovascular renal disease</u> <u>442X</u> DUE TO (b) DUE TO (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 <u>58</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>116 E. Main St. Salisbury, Md.</u> |
| 20f. (City or town) (County) (State) | | 21. I certify that I attended the deceased from <u>7-11-1958</u> , to <u>9-26-58</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9-23-58</u> , 19 <u>58</u> , and that death occurred at <u>8 P. M.</u> from the causes and on the date stated above. | |
| ACTUAL SIGNATURE <u>Phyllis A. Insley</u> | | DATE SIGNED <u>116 E. Main St. Salisbury, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Dr. Phyllis A. Insley</u> | | 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | |
| 22b. DATE THEREOF <u>9-28-58</u> | | 22c. NAME OF CEMETERY <u>St. Mary Episcopal</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Maryland</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 1 '58</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hines</u> | |



10740

CERTIFICATE OF DEATH

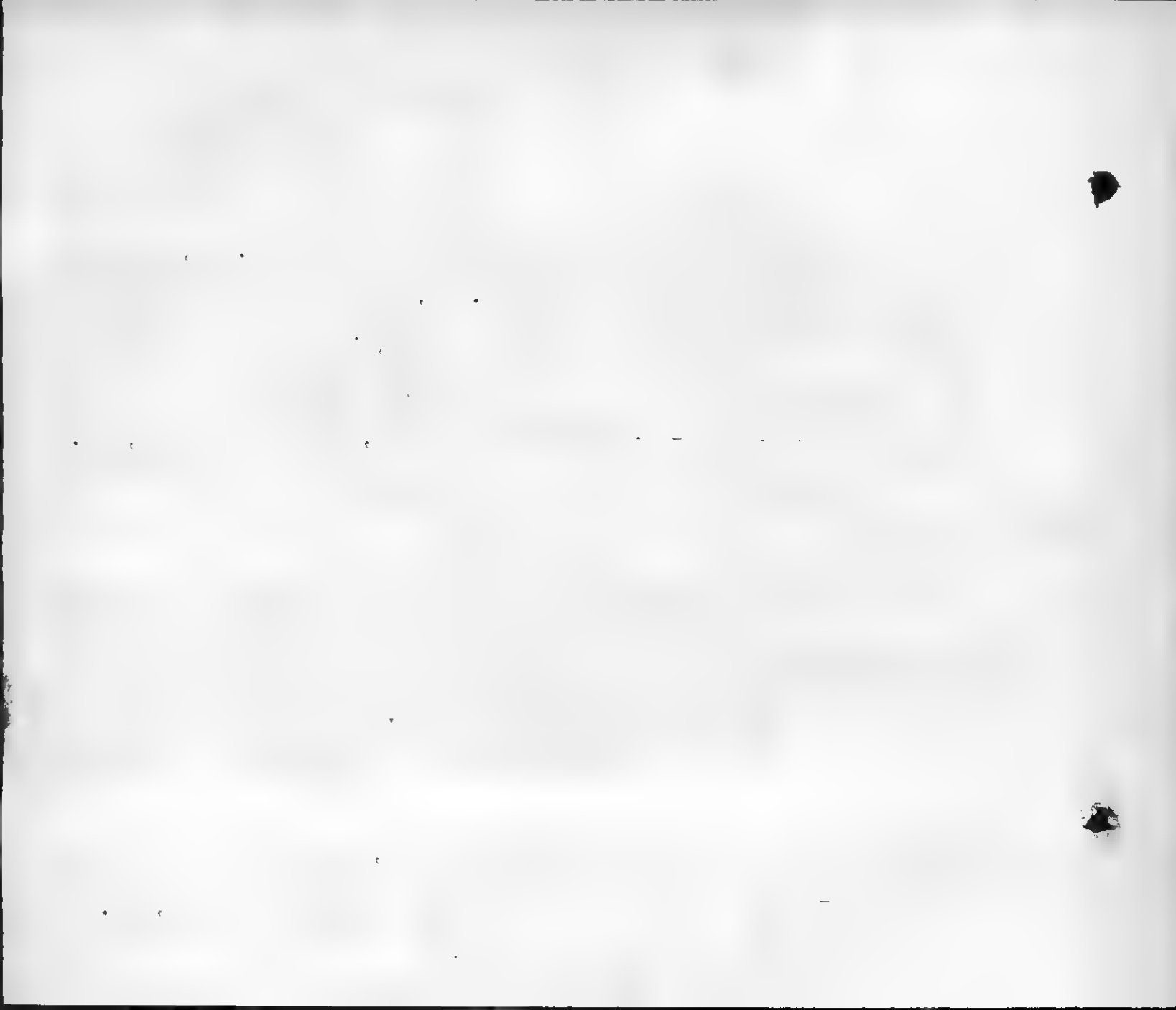
Reg. Dist. No.

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|--|----------------------------------|---|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs | | | | c. LENGTH OF STAY IN 1b 50 yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Main Street | | | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Mardela Springs | | | |
| f. STREET ADDRESS Main Street | | | | g. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last Samuel Windsor Bounds | | | | 4. DATE OF DEATH Month Day Year Sept. 9, 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Mar. 21, 1879 | | 9. AGE (In years last birthday) 79 yrs. | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Sawyer | | 10b. KIND OF BUSINESS OR INDUSTRY Lumber Mill | | 11. BIRTHPLACE (State or foreign country) Quantico, Md | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME John Bounds | | | | 14. MOTHER'S MAIDEN NAME Sallie Windsor | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) No | | 16. SOCIAL SECURITY NO. 216-10-2375 | | 17. INFORMANT Address Mrs Carl Metz, Mardela Springs, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Local Pneumonia 490 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 76 days |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | |
| 20c. TIME OF INJURY Hour a. m. _____ p. m. _____ Month _____ Day _____ Year 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from Sept. 6th , 19 58 , to Sept 9th , 19 58 , that I last saw the deceased alive on Sept. 9th , 19 58 , and that death occurred at 12:00 A.M. , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE William Emrich M.D. | | | | ADDRESS (Street, city or town, state) Hebron, Md | | DATE SIGNED Sept. 10-58 | |
| PHYSICIAN'S NAME (Type) William Emrich | | | | Hebron, Maryland | | | |
| 22a. BURIAL, CREMATION, OR OTHER DISPOSAL Burial | | 22b. DATE THEREOF 9-12-58 | | 22c. NAME OF CEMETERY OR CREMATORY Mardela | | 22d. LOCATION (City, town, or county) (State) Mardela Springs, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Charles H. Hanel, Hagerstown, Md. | | | | 24a. REC'D BY REGISTRAR DATE SEP 15 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kious | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10698

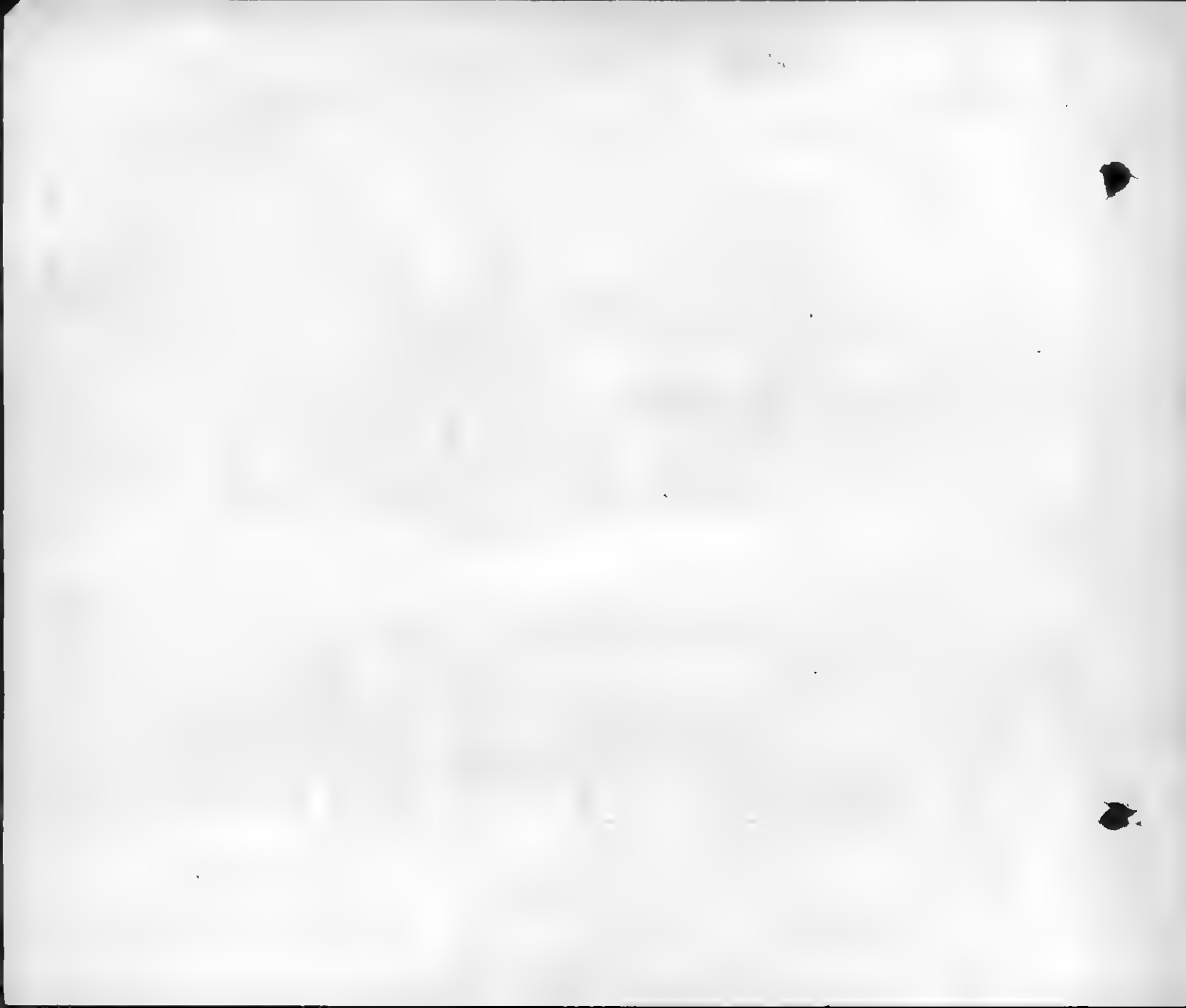
CERTIFICATE OF DEATH

Reg. Dist. No.

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|--|---------------------------------|---|-------------------------------------|---|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Frederick's General Hospital</u> | | | | d. STREET ADDRESS <u>12241</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>BROWN</u> | | | | 4. DATE OF DEATH Month <u>September</u> Day <u>11</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 6 1958</u> | | 9. AGE (In years last birthday) yrs <u>5</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>5</u> Days <u>5</u> Hours <u>5</u> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Robert L. Beathbury</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Mary H. Brown</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | | 17. INFORMANT <u>Mary H. Brown</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause pertaining for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Prematurity (Weight 1lb 11oz)</u> <u>762.5</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Partial atelectasis</u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept 6, 1958</u> , to <u>Sept. 11, 1958</u> , that I last saw the deceased alive on <u>Sept 11, 1958</u> , and that death occurred at <u>12:15 PM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>W. Sunderson</u> | | | | ADDRESS (Street, city or town, state) <u>762 Camden Ave Salisbury Md</u> | | DATE SIGNED <u>9/12/58</u> | |
| PHYSICIAN'S NAME (Type) <u>William H. Jones</u> | | | | | | | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF <u>9/11/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>House of Jacob</u> | | 22d. LOCATION (City, town, or county) (State) <u>Chambers, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William H. Jones</u> | | | | ADDRESS <u>Chambers, Md</u> | | 24a. REC'D BY REGISTRAR <u>SEP 16 58</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Hanks</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

10694

Reg. Dist. No.

10699

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland | | c. LENGTH OF STAY IN TB 2mo. 27 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Wallace Middle Duran Last Clark | | 4. DATE OF DEATH Month Sept. Day 1 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Aug. 7, 1901 |
| 9. AGE (In years last birthday) 57 yrs. | | IF UNDER 1 YEAR Months 57 | IF UNDER 24 HRS. Days 57 Hours 57 Min. 57 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming (Retired) | | 10b. KIND OF BUSINESS OR INDUSTRY Farmer | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Noah Clark | | 14. MOTHER'S MAIDEN NAME Gertrude Patiy Pittsville, Md. | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) unk (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO unk | |
| 17. INFORMANT Mrs. Ruth J. Twilley (Daughter) | | Hospital Records, Salisbury, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma laryngis with extensive metastases DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO | | INTERVAL BETWEEN ONSET AND DEATH 1 yr. 3 mos. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June 4, 1958 , to Sept. 1, 1958 , that I last saw the deceased alive on Sept. 1, 1958 , and that death occurred at 3:05 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED Sept. 1, 1958 | | | |
| ACTUAL SIGNATURE Dr. V. Juerman M.D. | | PHYSICIAN'S NAME (Type) V. Juerman, M.D. | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept. 3, 1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery | | 22d. LOCATION (City, town, or county) (State) Pittsville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY | | ADDRESS SALISBURY MARYLAND | |
| 24a. REC'D BY REGISTRAR DATE SEP 4 '58 | | 24b. REGISTRAR'S SIGNATURE Charles L. Hines | |

MEDICAL CERTIFICATION

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

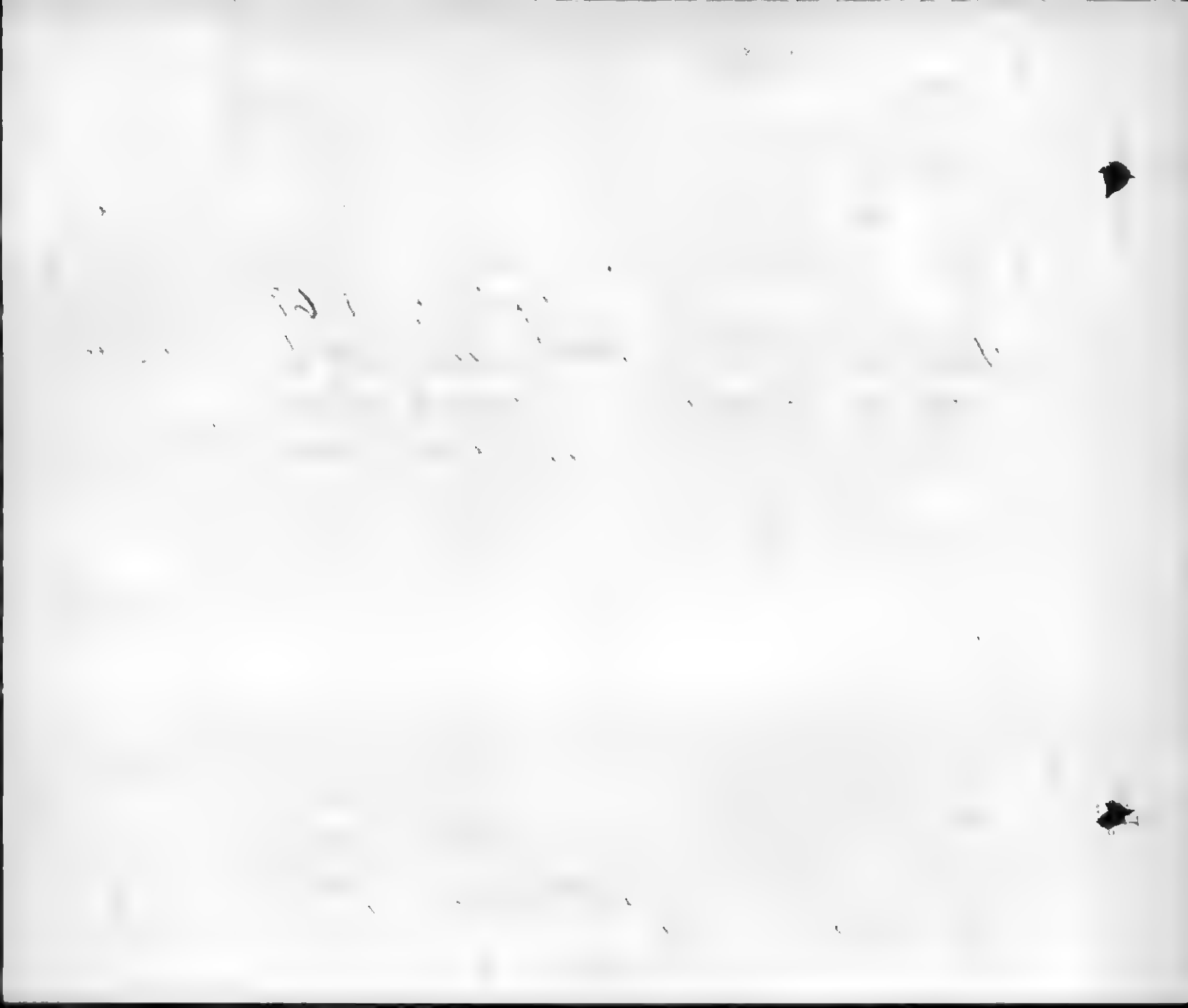
10700

CERTIFICATE OF DEATH

10695

Reg. Dist. No.

| | | | |
|--|-------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> c. LENGTH OF STAY IN 1b | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Willards</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u> d. STREET ADDRESS <u>R.F.D.</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Sadie</u> Middle <u>S.</u> Last <u>Collins</u> | | 4. DATE OF DEATH Month <u>September</u> Day <u>26</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 4, 1891</u> |
| 9. AGE (In years last birthday) <u>67</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Smack</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Davis</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <input checked="" type="checkbox"/> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>Mrs. Della Dennis</u> | | Address <u>Willards, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332x DUE TO (b) <u>Cerebral Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION ENTER IN PART II OF ITEM 18. <u>Arteriosclerotic Heart Disease; Cataracts right eye</u> INTERVAL BETWEEN ONSET AND DEATH <u>4 days</u> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | |
| 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Jan. 1956</u> to <u>Sept. 26, 1958</u> , that I last saw the deceased alive on <u>Sept. 26, 1958</u> , and that death occurred at <u>—</u> M., from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>David J. Sullivan</u> M.D. | | ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>Sept. 27, 1958</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u> | | 22b. DATE THEREOF <u>9/29/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>St. Pleasant</u> | | 22d. LOCATION (City, town, or county) (State) <u>Willards Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Peter Whaley Salisbury, Md.</u> | | 24a. REC'D BY REGISTRAR <u>SEP 29 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Wm. S. Thomas</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

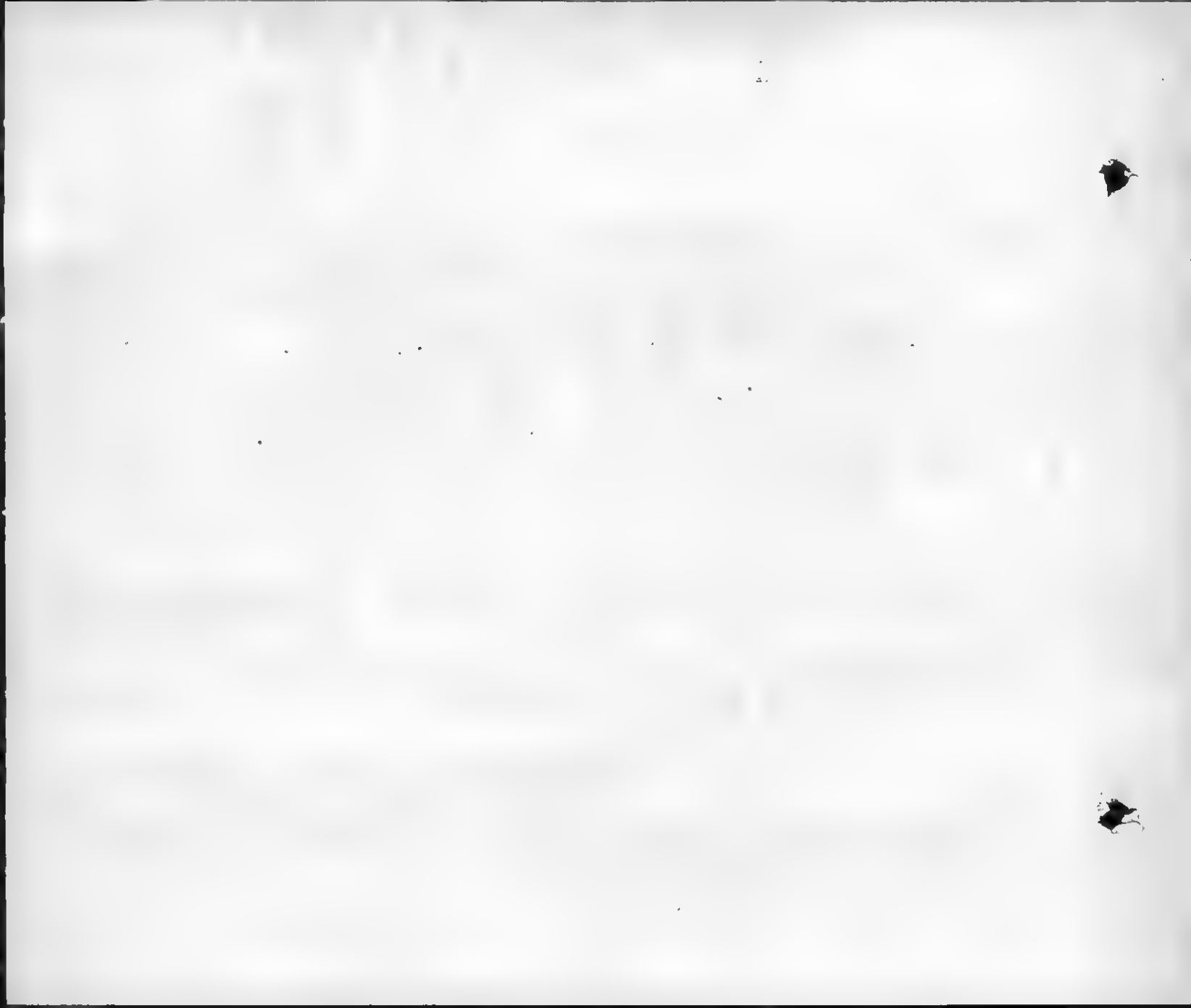
10701

CERTIFICATE OF DEATH

Reg. Dist. No.

10596

| | | | |
|---|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomac</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chincoteague</u> 83 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u> | | d. STREET ADDRESS <u>512 South Main St.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>William Thomas</u> Middle <u>Conant</u> Last <u>Conant</u> | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>2</u> Year <u>1958</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JUN 29 1881</u> |
| 9. AGE (In years last birthday) <u>77</u> yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>7</u> Days <u>18</u> Hours <u>18</u> Min <u>18</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Merchant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Self</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Chincoteague</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>William N Conant</u> | | 14. MOTHER'S MAIDEN NAME <u>Sarah Melvin</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give year or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>RE ROY CONANT-POCOMOKE MD.</u> | |
| 17. INFORMANT <u>RE ROY CONANT-POCOMOKE MD.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH <u>18 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at _____ M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>David L. Schum</u> M.D. | | ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>David L. Schum</u> | | DATE SIGNED <u>Sept 2, 1958</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>Sept 4, 1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>DOWNING CEM.</u> | | 22d. LOCATION (City, town, or county) (State) <u>CAK HALL VA</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Salyer</u> | | 24a. REC'D BY REGISTRAR DATE <u>SEP 5 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur L. Howard</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10702

CERTIFICATE OF DEATH

10697

Reg. Dist. No.

| | | | |
|---|------------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury c. LENGTH OF STAY IN 1b 3 Days | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE MARYLAND b. COUNTY WORCESTER c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SNOW HILL d. STREET ADDRESS R1 Box 125 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) HESTER First Middle Last DALE | | 4. DATE OF DEATH Month Day Year SEPTEMBER 13 1958 | |
| 5. SEX FEMALE | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 3-11-1919 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) domestic | | 10b. KIND OF BUSINESS OR INDUSTRY Housework | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME Thomas Bishop | | 14. MOTHER'S MAIDEN NAME Laura Beckett | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO 216-18-2239 | |
| 17. INFORMANT Clifton Dale, Snow Hill, Md, Rt #1 | | Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 3x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO (c) Terminal renal insufficiency Hypertensive Cardiovascular Disease 6 yrs PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Congestive Heart Failure | | INTERVAL BETWEEN ONSET AND DEATH 3-6 mos. 6 yrs | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9/10 , 19 58 , to 9/13 , 19 58 , that I last saw the deceased alive on 9/12 , 19 58 , and that death occurred at 3:30 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) Pinebluff Rd. Salisbury, Md DATE SIGNED 9/14/58 ACTUAL SIGNATURE Rufus S Gardner Jr M.D. PHYSICIAN'S NAME (Type) RUFUS S GARDNER JR SALISBURY, MD | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9-16-1958 | |
| 22c. NAME OF CEMETERY OR CREMATORY Mt. Wesley cemetery | | 22d. LOCATION (City, town, or county) (State) Nr. Snow Hill, Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE J. F. Stewart Funeral Home, Salisbury, Md | | 24a. REC'D BY REGISTRAR DATE SEP 22 '58 | |
| 24b. REGISTRAR'S SIGNATURE Clifton S. Hume | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10703

CERTIFICATE OF DEATH

10098

Reg. Dist. No.

| | | | | | | | |
|---|-------------------------------|--|--------------------------------------|---|--|--|---------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Princess Anne</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u> | | | | d. STREET ADDRESS <u>248 Somerset Ave</u> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>David Dashiield</u> | | | | 4. DATE OF DEATH Month Day Year <u>September 3- 1958</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>white</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Sept 12 1880</u> | | 9. AGE (In years last birthday) yrs. <u>77</u> | | IF UNDER 1 YEAR IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Portician</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Tuxedo</u> | | 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Charles Dashiield</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Sarah Simpson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO <u>615-38-0230</u> | | 17. INFORMANT <u>Phyllis Kedden Princess Anne Md</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Degenerative Heart Disease</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Unknown</u> DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u> | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that I attended the deceased from <u>8-22-1958</u> to <u>8-3-1958</u> , that I last saw the deceased alive on <u>12-30</u> , 19 <u>58</u> , and that death occurred at <u>12:30</u> PM, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>William R. Ellis</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> DATE SIGNED <u>9-5-58</u> | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>9/6/58</u> | | <u>St Andrews</u> | | <u>Princess Anne Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Hannon</u> ADDRESS <u>Princess Anne Md</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>SEP 8 58</u> | | 24b. REGISTRAR'S SIGNATURE <u>William R. Ellis</u> | |



10704

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> c. LENGTH OF STAY IN 1b <u>11 DAYS</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u> | | d. STREET ADDRESS <u>1 HOLO CLAIBORNE ST.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>SALLY DASHIELL</u> | | 4. DATE OF DEATH <u>Sept 30</u> Month <u>30</u> Day <u>19</u> Year <u>58</u> | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>ROC -</u> |
| 9. AGE (In years last birthday) yrs <u>58</u> | | 10. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min <u>0</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>domestic</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Palestine</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Delaney Covington</u> | | 14. MOTHER'S MAIDEN NAME <u>Frances Harris</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>none</u> | |
| 17. INFORMANT <u>Wm Covington</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) <u>diabetes mellitus</u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH: (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Mar 54</u> to <u>Sept 30</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>Sept 30</u> , 19 <u>58</u> , and that death occurred at <u>7:00</u> A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Alberta Mattox</u> | | ADDRESS (Street, city or town, state) <u>711 Camden Ave Salisbury, Md</u> | |
| PHYSICIAN'S NAME (Type) <u>Booker McQuest</u> | | DATE SIGNED <u>10/2/58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Oct 5/1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Palestine Rd cem</u> | 22d. LOCATION (City, town, or county) (State) <u>Palestine Md</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Booker McQuest</u> | | 24a. REC'D BY REGISTRAR DATE <u>OCT 8 '58</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>E. Evans</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL ■■ ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

10699

Reg. Dist. No.

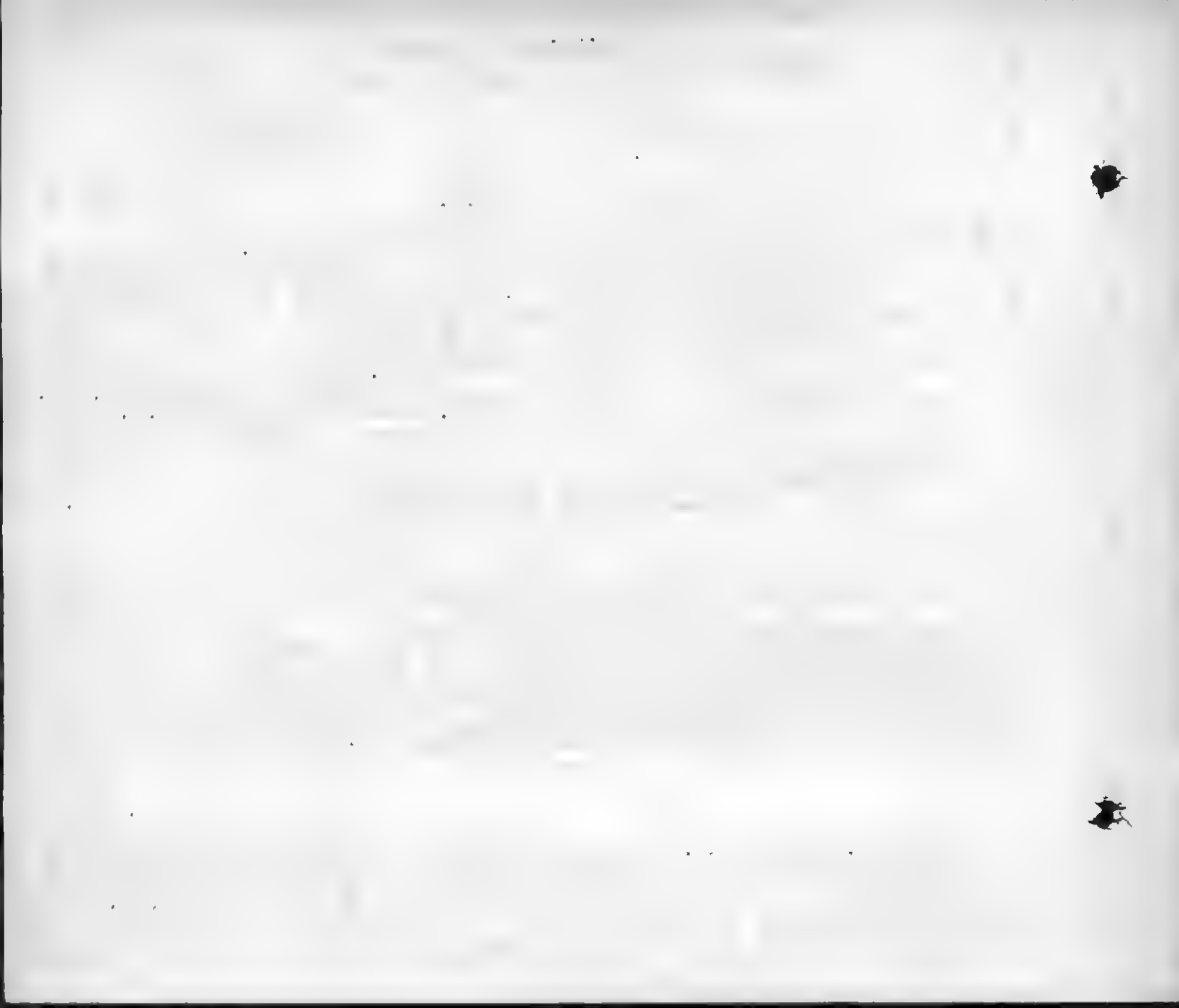
10705

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH o. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Worcester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury, Maryland | | c. LENGTH OF STAY IN 1b 2mo. 13days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital | | d. STREET ADDRESS B.D.# 2 | |
| e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Alice Middle Davis Last Davis | | 4. DATE OF DEATH Month Sept. Day 14 Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Jan. 14, 1886 |
| 9. AGE (In years last birthday) yrs. 72 | | IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) unk | | 10b. KIND OF BUSINESS OR INDUSTRY unk | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME unk | | 14. MOTHER'S MAIDEN NAME Sarah Davis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) unk | | 16. SOCIAL SECURITY NO unk | |
| 17. INFORMANT Mrs. Laura White (Niece) | | R.D.# 2 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO decompensated with Cardiomegaly Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 10 mo. | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Diabetes Mellitus | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) | |
| 20c. TIME OF INJURY Month. 19 Day. 19 Year. 19 Hour a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from July 1, 19 58 to Sept. 14, 19 58 that I last saw the deceased alive on Sept. 14, 19 58 and that death occurred at 12:30 AM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Salisbury, Maryland DATE SIGNED Sept. 14, 1958 | | | |
| ACTUAL SIGNATURE Dr. V. Juerman | | M.D. Salisbury, Maryland | |
| PHYSICIAN'S NAME (Type) V. Juerman, M.D. | | Deer's Head State Hospital | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF | 22c. NAME OF CEMETERY OR CREMATORY | 22d. LOCATION (City, town, or county) (State) |
| Burial | Sept 16/58 | Mt Zion Cemetery | Near Powellville, Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY | | 24a. REC'D BY REGISTRAR DATE SEP 16 58 | |
| ADDRESS SALISBURY MARYLAND | | 24b. REGISTRAR'S SIGNATURE William S. Kline | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10706

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wico.</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | | c. LENGTH OF STAY IN 1b <u>1 day</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3 NAME OF DECEASED (Type or print) <u>Blanche</u> ^{1st} <u>ESTHER</u> ^{1st} <u>Davis</u> ^{1st} | | | | 4. DATE OF DEATH Month <u>September</u> Day <u>9</u> Year <u>1958</u> | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Mar. 10, 1898</u> | |
| 9. AGE (In years last birthday) yrs. <u>60</u> | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housekeeper</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Benjamin F. Davis</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Esther V. Davis Harris</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>no</u> | | | | 16. SOCIAL SECURITY NO. <u>none</u> | | 17. INFORMANT <u>Anna Davis, same</u> Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>31X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u> </u> DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs.</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>58</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>Sept 8, 1958</u> to <u>Sept 9, 1958</u> , that I last saw the deceased alive on <u>Sept 9, 1958</u> , and that death occurred at <u>8:40 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Thomas C. Hill, Jr.</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Pine Bluff Road</u> DATE SIGNED <u>9/9/58</u> | | | |
| PRINTED NAME (Type) <u>Thomas C. Hill, Jr.</u> | | | | <u>Salisbury, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF | | 22c. NAME OF CEMETERY OR CREMATORY | | 22d. LOCATION (City, town, or county) (State) | |
| <u>Burial</u> | | <u>9/12/58</u> | | <u>Hebron Cemetery</u> | | <u>Hebron Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co.</u> ADDRESS <u>Salisbury</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>SEP 15 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Carlton S. Kraus</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



FOR STATE
HEALTH DEPT.

Item 18 Film 234 8-24-58
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10707

Reg. Dist. No.

10701

| | | | |
|---|---|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> | |
| c. LENGTH OF STAY IN 1b | | d. STREET ADDRESS <u>RFD # 2</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u> | | e. IS RESIDENT ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Romelle</u> <u>Dennis</u> | 8. DATE OF DEATH Month Day Year <u>9</u> <u>15</u> <u>19 58</u> | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. AGE (In years last birthday) yrs. <u>6</u> Months <u>6</u> Days <u>19</u> Min. <u>58</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>Philip Dennis</u> | | 14. MOTHER'S MAIDEN NAME <u>Josephine</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO <u>None</u> | |
| 17. INFORMANT <u>Mrs. Josephine Dennis, Pocomoke, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gastro-enteritis due to Staphylococcus aureus</u> <u>049.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Child arrived in Accident room dead on arrival.</u> (c) <u>Child arrived in Accident room dead on arrival.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Child arrived in Accident room dead on arrival.</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Earl L. Royer</u> | | DATE SIGNED <u>9-18-58</u> | |
| EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>9-18-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Hall's Hill</u> | 22d. LOCATION (City, town, or county) (State) <u>Pocomoke, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u> | | 24a. REC'D BY REGISTRAR <u>SEP 22 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for file. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

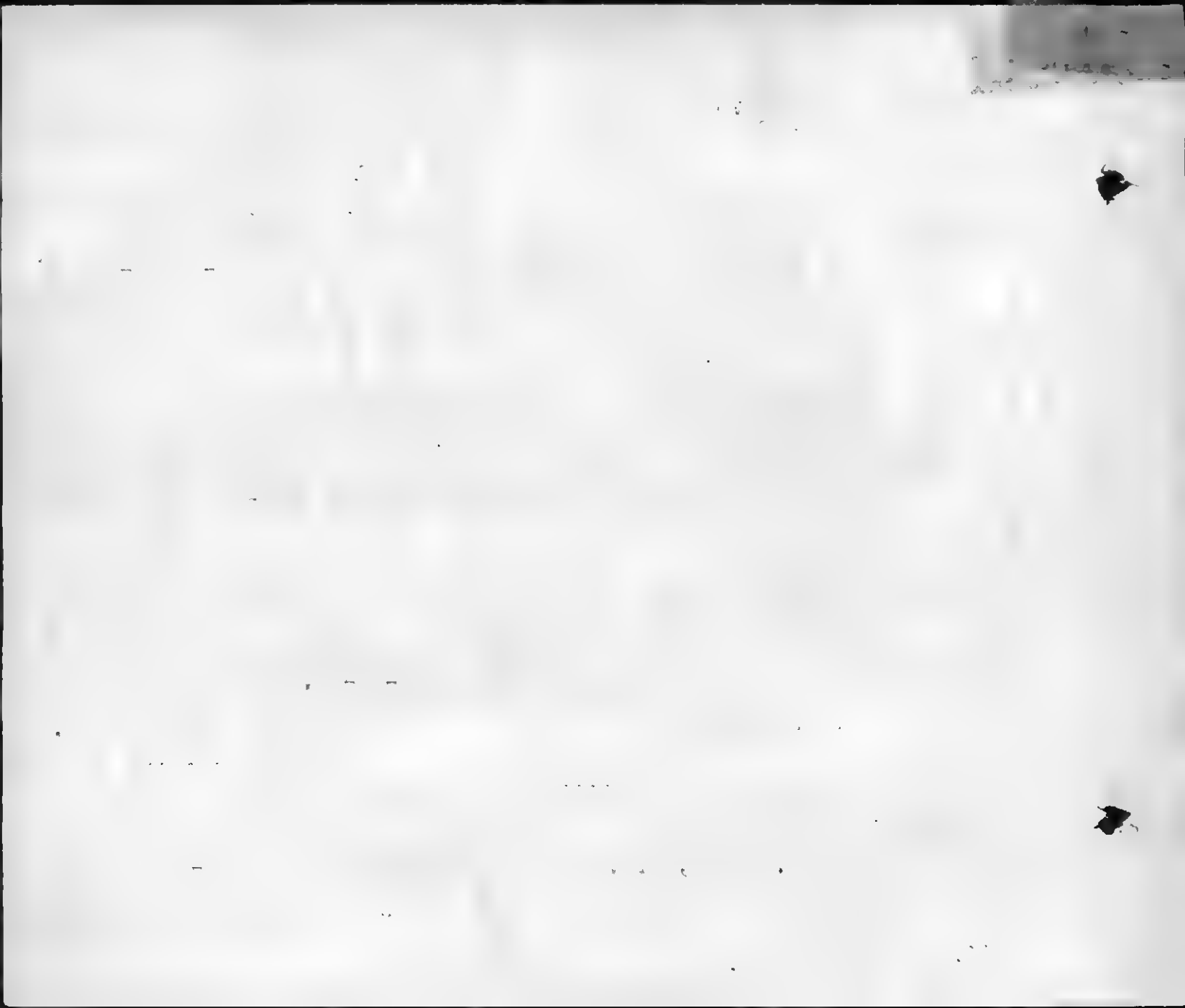
10702

FOR ST.
HEALTH DEPT.

Reg. Dist. No.

| | | | |
|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Worcester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 2 Days | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Peninsula General Hospital | | d. STREET ADDRESS R F D # 1 Box 43 | |
| 3. NAME OF DECEASED (Type or print) Frances Dennis Deshields | | 4. DATE OF DEATH Month 9- Day 29- Year 19 58 | |
| 5. SEX F | 6. COLOR OR RACE C | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Oct. 13 - 1923 |
| 9. AGE (Last birthday) 34 1/2 | | 10. UNDER 1 YEAR Months Days Hours Min. 34 1/2 | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housework | | 10b. KIND OF BUSINESS OR INDUSTRY Private Family | |
| 11. BIRTHPLACE (State or foreign country) Snow Hill, Md | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Orvin Dennis | | 14. MOTHER'S MAIDEN NAME Viola Schoolfield | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. 213-24-1364 | |
| 17. INFORMANT Mrs. Viola S. Dennis, Snow Hill, Md | | Address Rte #1 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Tetanus from puncture wound of foot- | | | |
| Conditions, if any, which gave rise to immediate cause (b) 061X | | | |
| (c) DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 13.0 | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) Stuck a stick in foot on 9-22-58. | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 9-22-58 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Home | 20f. (City or town) (County) (State) Snow Hill Worcester Md. |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE Earl L. Royer | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) Earl L. Royer, M.D. | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | 22b. DATE THEREOF Oct 3/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY St James Cemetery | | 22d. LOCATION (City, town, or county) (State) Snow Hill Md | |
| 23. FUNERAL DIRECTOR'S SIGNATURE May E. Dennis | | 24a. REC'D BY REGISTRAR DATE OCT 6 '58 | |
| 24b. REGISTRAR'S SIGNATURE Arthur S. Kraus | | DATE SIGNED 10-1-58 | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10709

CERTIFICATE OF DEATH

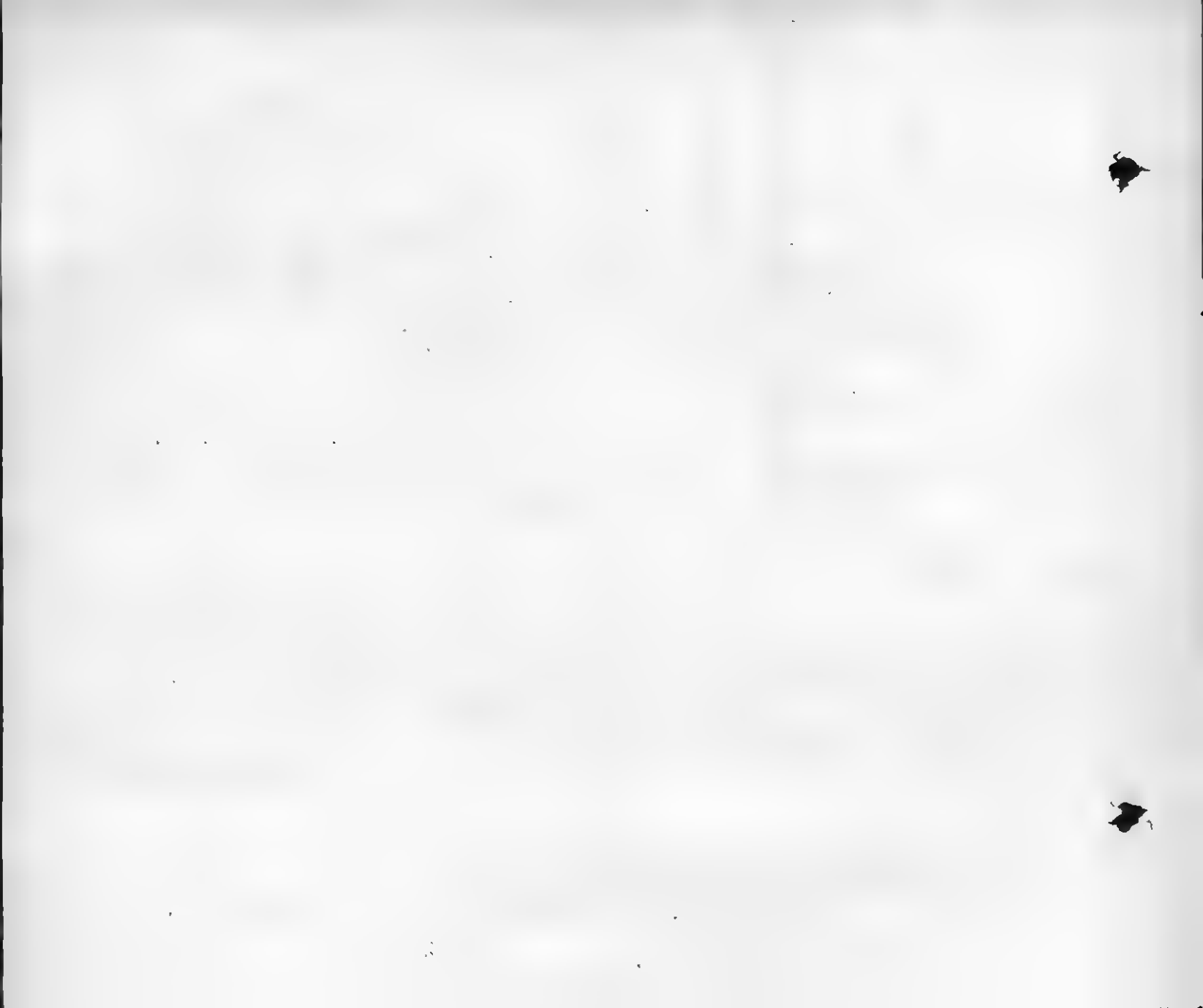
10703

Reg. Dist. No.

| | | | |
|--|--|--|--|
| 1 PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived If institution Residence before admision) a. STATE <u>Maryland</u> b. COUNTY <u>Somerset</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Marion Station</u> <u>14X</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Springhill Sanitarium, Inc.</u> | | d. STREET ADDRESS <u>RFD</u> | |
| 3 NAME OF DECEASED (Type or print) First <u>Mrs. Allie</u> Middle <u>Forsyth</u> Last <u>Forsyth</u> | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>22</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 24, 1868</u> |
| 9. AGE (In years last birthday) <u>89</u> | | IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u> | 11 BIRTHPLACE (State or foreign country) <u>Bucyrus, Ohio</u> |
| 12 CITIZEN OF WHAT COUNTRY <u>USA</u> | | 13. FATHER'S NAME <u>Frederick Henry Tipple</u> | |
| 14 MOTHER'S MAIDEN NAME <u>Anna ?</u> | | 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) <u>None</u> | |
| 16 SOCIAL SECURITY NO <u>None</u> | | 17. INFORMANT Address <u>Mrs. Stella Bradshaw, Crisfield, Md.</u> | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-vascular renal disease</u> <u>442X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u> | | | INTERVAL BETWEEN ONSET AND DEATH <u>5 years</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <u>Feb. 1955</u> to <u>9-22, 1958</u> , that I last saw the deceased alive on <u>9-20, 1958</u> , and that death occurred at <u>8:30 P.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Philip A. Insley</u> | | ADDRESS (Street, city or town, state) <u>Salisbury, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>Philip A. Insley</u> | | DATE SIGNED | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE WHEREOF <u>9/24/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Cemetery</u> | 22d. LOCATION (City, town, or county) (State) <u>Marion Station, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <u>Bradshaw & Sons, Crisfield, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>SEP 25 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> |

MEDICAL CERTIFICATION

TO HONORARY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10714

FOR STATE
HEALTH DEPT.

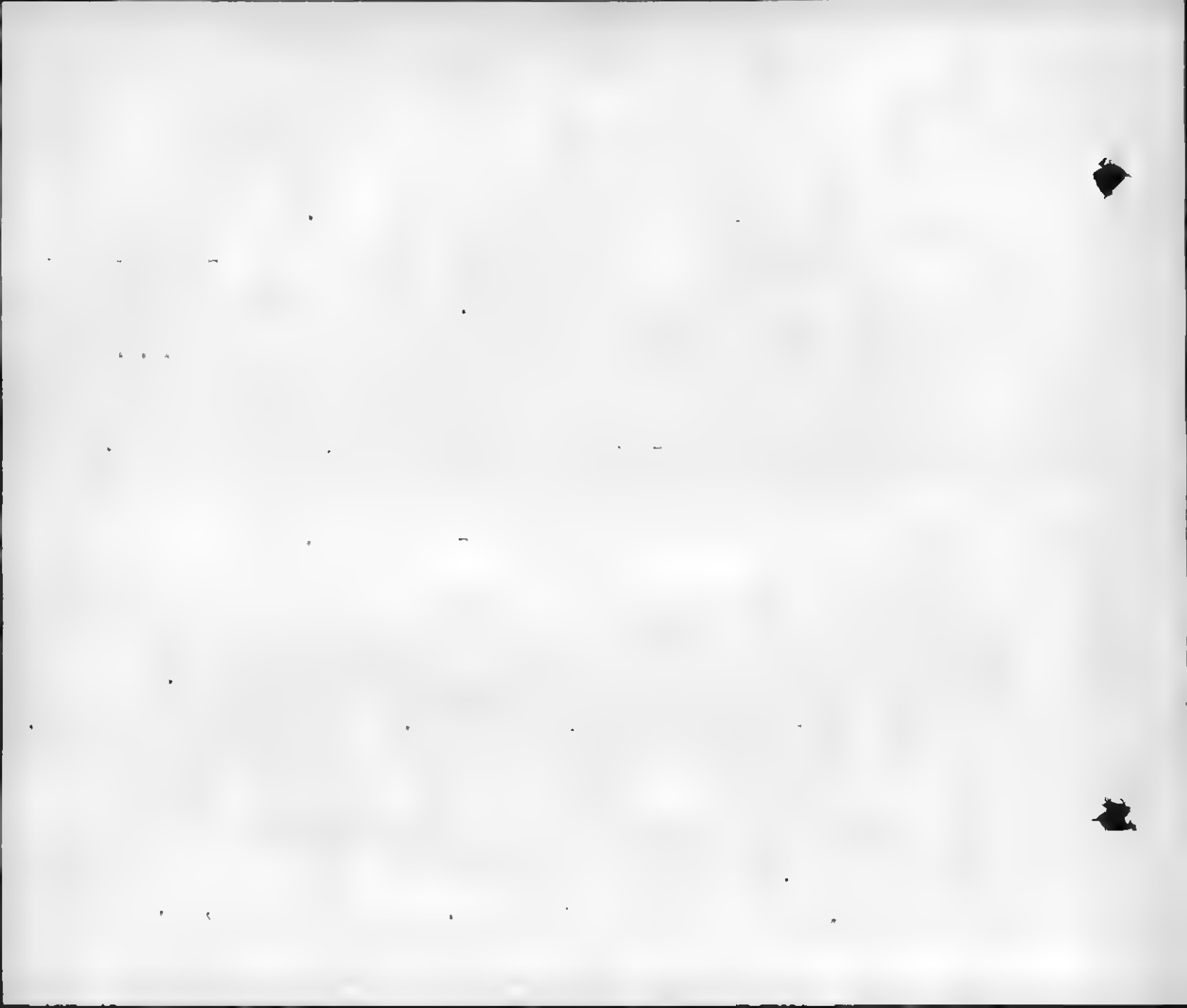
10710

Item 7 Film 233 9-15-58 et

Reg. Dist. No.

| | | | | | |
|--|--|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> | | | 2. USUAL RESIDENCE (Where deceased lived. If institution—Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u> | | | d. STREET ADDRESS <u>413 Barks St.</u> | | |
| 3. NAME OF DECEASED (Type or print) <u>Aaron</u> <u>Leo</u> <u>Golden</u> | | | 4. DATE OF DEATH Month <u>9</u> Day <u>7</u> Year <u>19 58</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Nov. 25, 1939</u> | | 9. AGE (In years last birthday) <u>18</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Factory</u> | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> |
| 13. FATHER'S NAME <u>Edward Golden</u> | | | 14. MOTHER'S MAIDEN NAME <u>Marie Copps</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. <u>217-36-1624</u> | 17. INFORMANT <u>Marie Golden, Pocomoke City, Md.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Broncho-pneumonia</u> | | | | | <u>2 days</u> |
| DUE TO (b) <u>Cerebral hemorrhage-traumatic.</u> | | | | | <u>7 days</u> |
| DUE TO (c) _____ | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Passenger in car involved in a collision.</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>8-31-19 58</u> p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Snow Hill Rd.</u> | 20f. (City or town) <u>Pocomoke</u> | (County) <u>Worcester</u> | (State) <u>Md.</u> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Earl L. Royer</u> | | M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | DATE SIGNED <u>2-8-58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>9/14/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Halls Hill Cem.</u> | | 22d. LOCATION (City, town, or county) <u>Pocomoke City, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton</u> | | ADDRESS <u>New Church, Md.</u> | | 24a. REC'D BY REGISTRAR DATE <u>SEP 11 '58</u> | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. ...</u> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be given to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.



1
 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

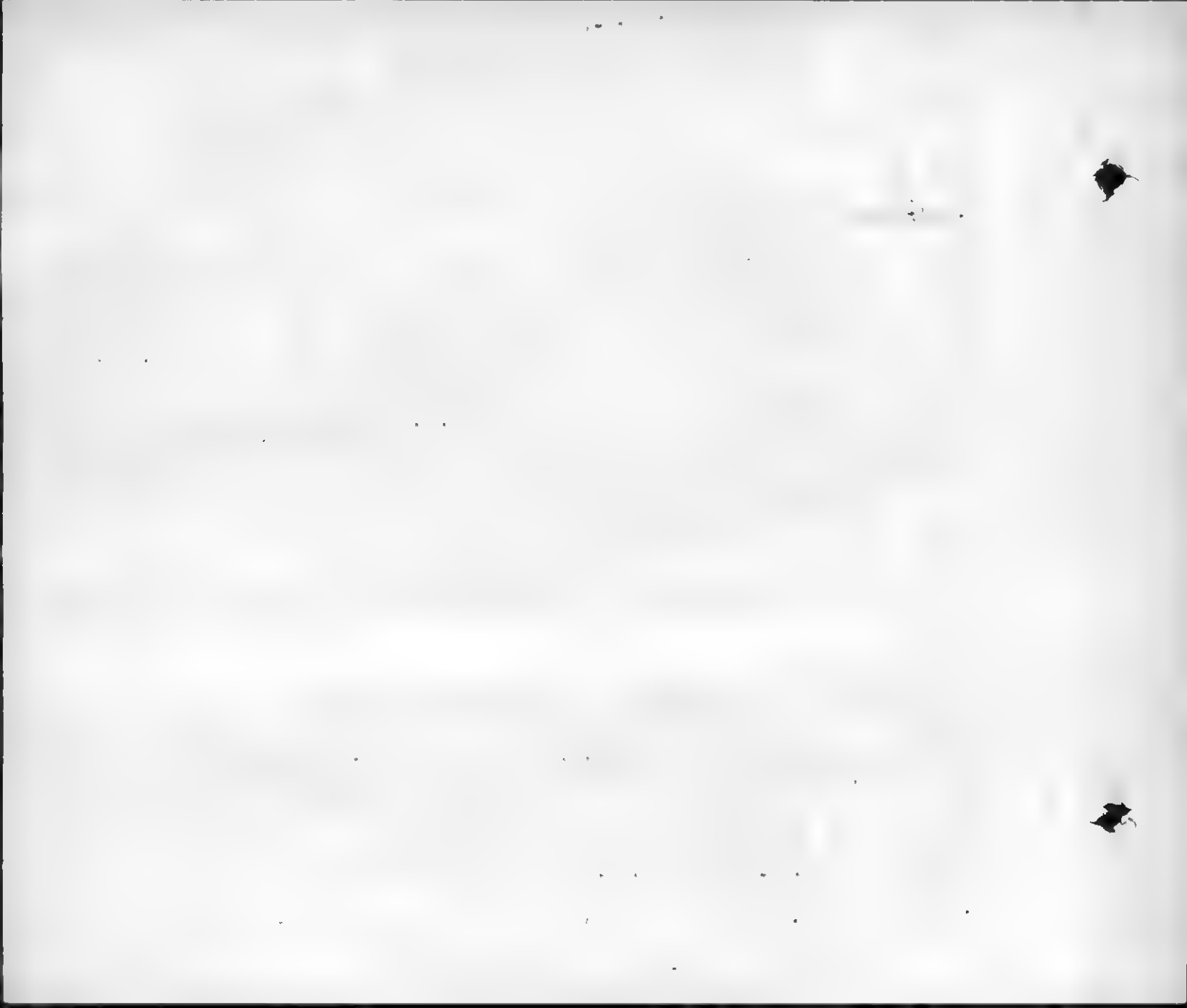
10705

10711

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 17 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital | | e. STREET ADDRESS West Church Street | |
| 3. NAME OF DECEASED (Type or print) First Annie Middle Ellen Last Hastings | | 4. DATE OF DEATH Month September Day 25 Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 4, 1899 |
| 9. AGE (In years last birthday) 59 yrs | | 10. IF UNDER 1 YEAR Months Days Hours Min | 11. IF UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work | | 10b. KIND OF BUSINESS OR INDUSTRY None | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Granville Knowles | | 14. MOTHER'S MAIDEN NAME Blanche Ellis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) Unk | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT Mr. C. Howard Hastings (Husband) Hebron, Maryland Hospital Records, Salisbury, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cerebral embolism 416X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Rheumatic heart disease DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | INTERVAL BETWEEN ONSET AND DEATH 24 hrs Unknown |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) |
| 20f. (City or town) | | (County) (State) | |
| 21. I certify that I attended the deceased from Sept. 8 , 19 58 , to Sept. 25 , 19 58 , that I last saw the deceased alive on Sept. 25 , 19 58 , and that death occurred at 2:45 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <i>L. V. Maldve</i> | | ADDRESS (Street, city or town, state) Deer's Head State Hospital | |
| PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. | | DATE SIGNED 9/25/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept. 27/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Hebron, Cemetery | | 22d. LOCATION (City, town, or county) (State) Hebron, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY | | 24a. REC'D BY REGISTRAR SEP 29 '58 | |
| ADDRESS SALISBURY MARYLAND | | 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraw</i> | |



10741

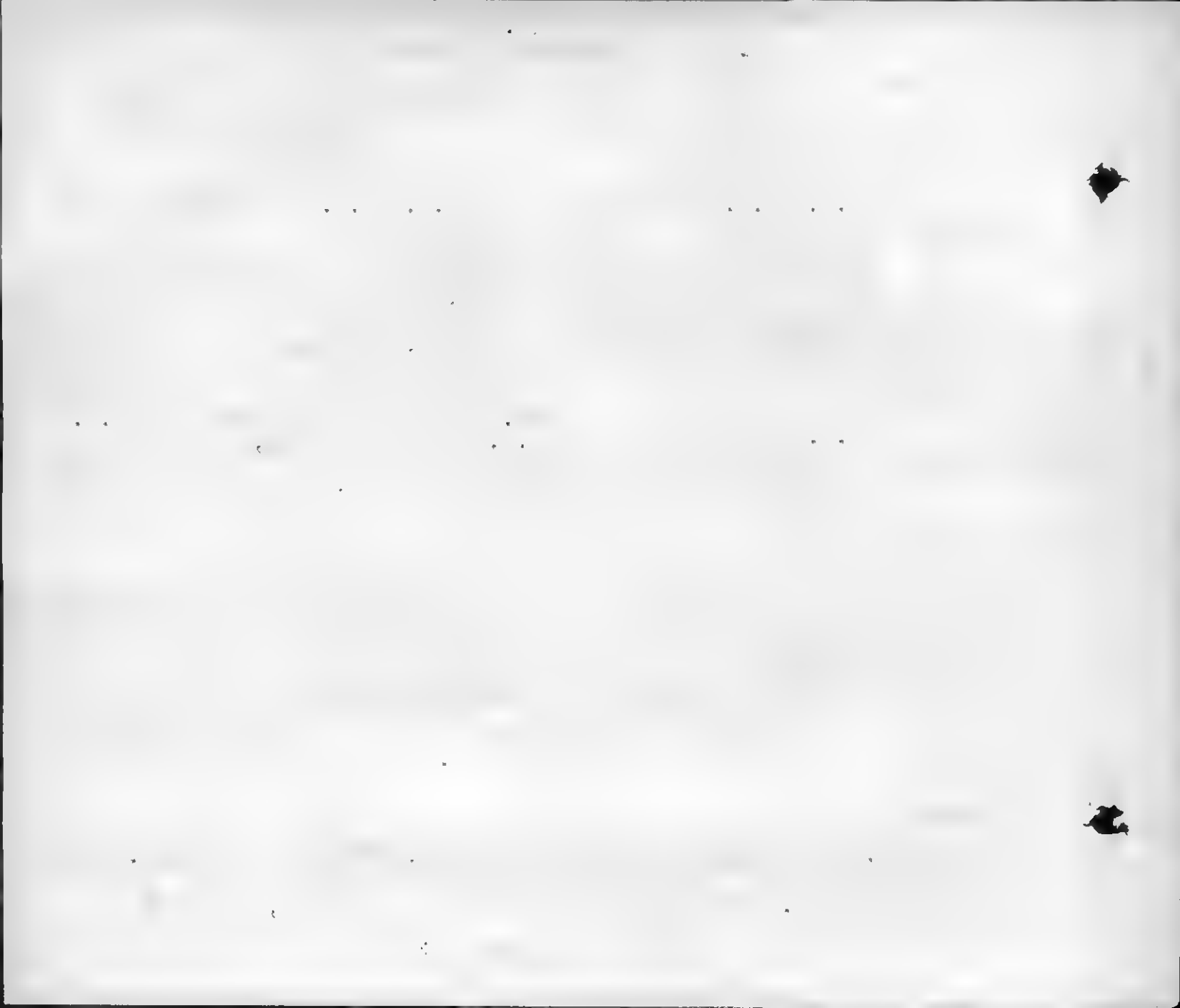
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron (Rural) | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hebron (Rural) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION R.D.#(U.S.Route #50) | | d. STREET ADDRESS R.D.#(U.S.Route #50) e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last CLIFTON JACKSON HUGHES | | 4. DATE OF DEATH Month Day Year SEPTEMBER 17 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH May 9, 1909 |
| 9. AGE (In years last birthday) 49 | | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Restaurant Owner and Operator | | 10b. KIND OF BUSINESS OR INDUSTRY Hebron, Maryland | |
| 11. BIRTHPLACE (State or foreign country) U S A | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Louis Hughes | | 14. MOTHER'S MAIDEN NAME Nannie Bennett | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes (If yes, give war or dates of service) W.W.II | | 16. SOCIAL SECURITY NO. Mrs. Dorothy Jeane Hughes (Wife) R.D.# (U.S.Route #50) Hebron, Maryland | |
| 17. INFORMANT Mrs. Dorothy Jeane Hughes (Wife) R.D.# (U.S.Route #50) Hebron, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary Thrombosis DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 1 day DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 1 day | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Sept 12, 1958 to Sept 17, 1958 that I last saw the deceased alive on Sept 17, 1958 and that death occurred at 1:15 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Dr. William Emrich M.D. | | ADDRESS (Street, city or town, state) Hebron, Maryland DATE SIGNED Sept. 15/58 | |
| PHYSICIAN'S NAME (Type) Dr. William Emrich | | Hebron, Maryland Sept. 15/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Sept. 20/58 | 22c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery | 22d. LOCATION (City, town, or county) (State) Hebron, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY ADDRESS SALISBURY MARYLAND | | 24a. REC'D BY REGISTRAR SEP 22 '58 24b. REGISTRAR'S SIGNATURE Arthur S. [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

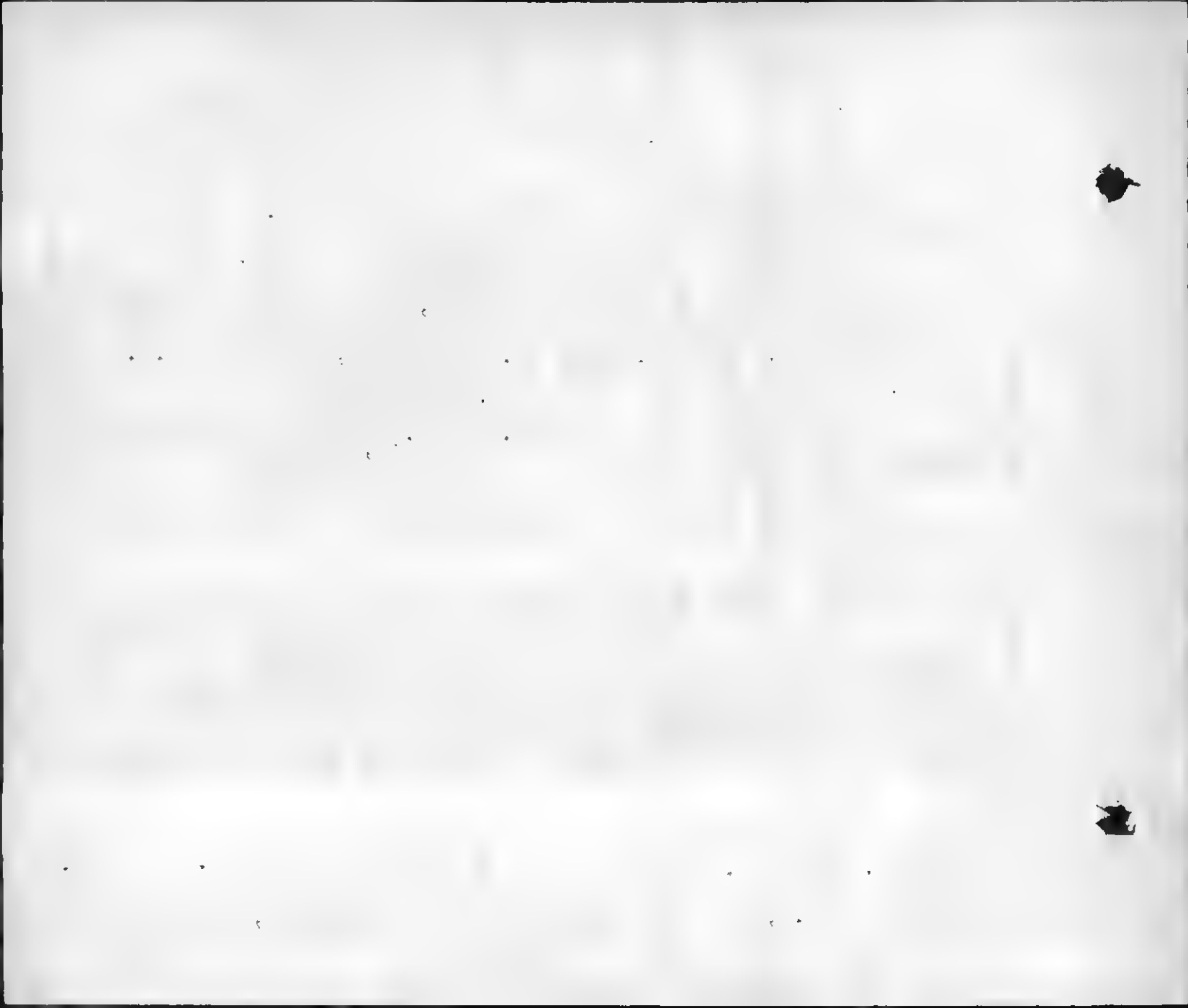


FOR STATE
HEALTH DEPT.

DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMQ. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 2/57

| MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|---|--|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| Reg. Dist. No. 10707 | | | | | | | | | | | |
| 1. PLACE OF DEATH a. COUNTY Wicomico | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | | c. LENGTH OF STAY IN 1b | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 521 Wailes St | | | | | | | | d. STREET ADDRESS 521 Wailes St. | | e. IS RE-DECEASED ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) | | First PAUL | | Middle EDWARD | | Last JEFFERSON | | 4. DATE OF DEATH | | Month SEPT. Day 1 st Year 19 58 | |
| 5. SEX Male | | 6. COLOR OR RACE White | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 8. DATE OF BIRTH March 18, 1919 | | 9. AGE (in years last birthday) 39 yrs. | | 10. IF UNDER 1 YEAR 5 Months 13 Days 13 Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer - - - Worked for Roofing Co., Georgetown, Delaware | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) U.S.A | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Ralph Jefferson | | | | 14. MOTHER'S MAIDEN NAME Hattie Wilson | | | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Unk | | | | 16. SOCIAL SECURITY NO. | | | | 17. INFORMANT Mrs. Mary E. Jefferson (Wife) 521 Wailes St Salisbury, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 581.0 DUE TO Constriction, Edema of brain, fatty degeneration of liver -- severe Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral DUE TO (c) | | | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Philip A. Insley M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | DATE SIGNED Sept. 2 /1958 | | | |
| EXAMINER'S NAME (Type) Dr. Philip A. Insley | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept. 4, 1958 | | 22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | | | | 22d. LOCATION (City, town or county) (State) Salisbury, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY | | | | ADDRESS SALISBURY MARYLAND | | | | 24a. REC'D BY REGISTRAR SEP 4 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Huns | |



10713

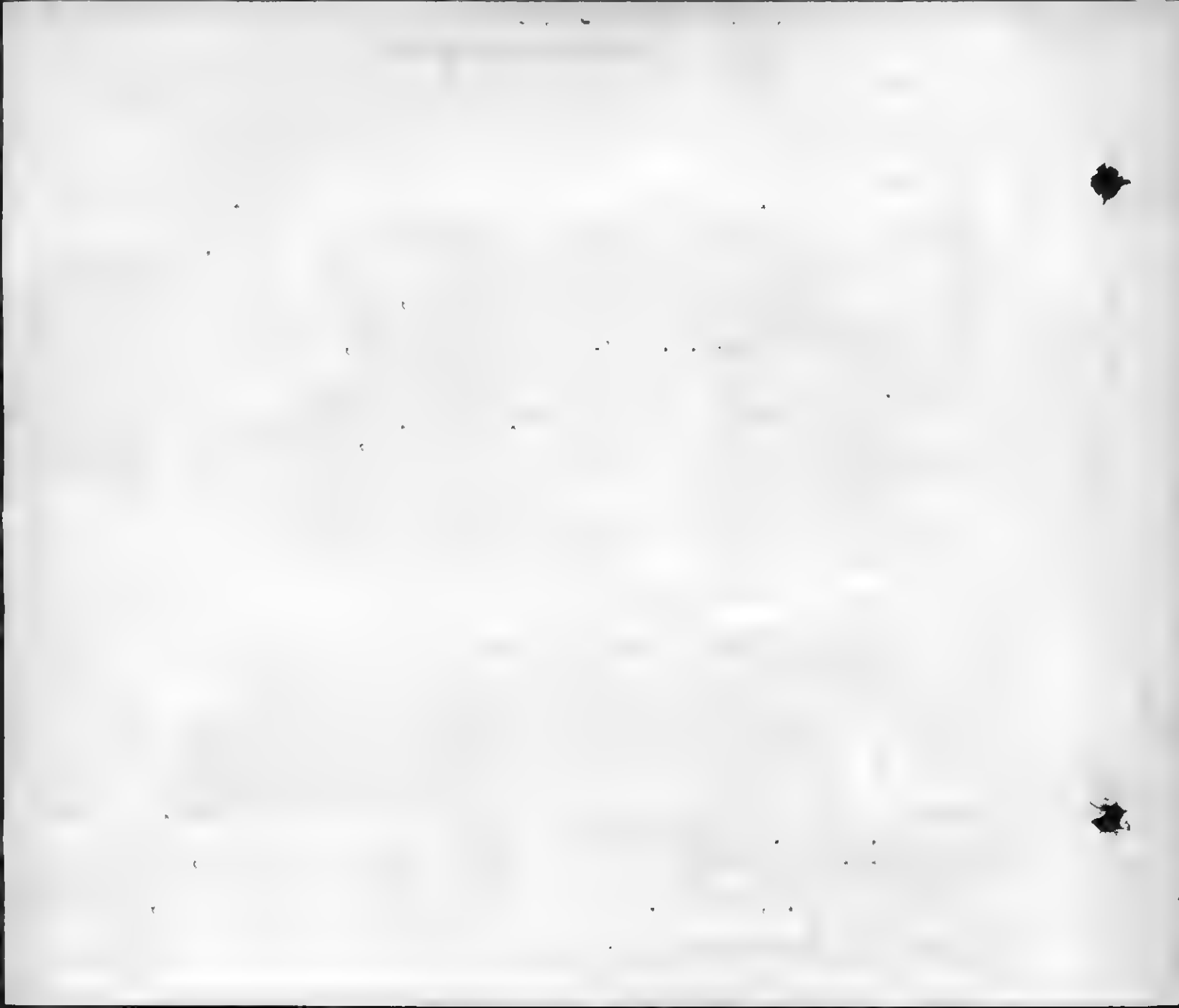
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|--|--|
| 1 PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Maryland b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pen Gen. Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3 NAME OF DECEASED (Type or print) First ELIJAH Middle FREDRICK Last KELLY | | 4 DATE OF DEATH Month SEPT. Day 4th Year 19 58 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH October 8, 1898 |
| 9. AGE (In years last birthday) 59 yrs | | 10. UNDER 1 YEAR Months 5 Days 16 Hours 4 M. 00 | 11. UNDER 24 HRS |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Rural Mail Carrier-U.S. Gov. | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Powellville, Maryland | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME John W. Kelly | | 14. MOTHER'S MAIDEN NAME Catherine Lewis | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO | |
| 17. INFORMANT Mrs. Edith W. Kelly (Wife) | | Address Ocean City Blvd, Pittsville, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARCINOMA BLADDER 181.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | INTERVAL BETWEEN ONSET AND DEATH 16 YRS 4 MO. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) _____ (County) _____ (State) _____ |
| 21. I certify that I attended the deceased from 5/24 , 19 52 , to 9/4 , 19 58 , that I last saw the deceased alive on 9/4 , 19 58 , and that death occurred at 2:00 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED Sept. 4 1958 | | | |
| ACTUAL SIGNATURE John M. Bloxom M.D. | | PHYSICIAN'S NAME (Type) Dr. H. Gray Reeves Medical Center-Salisbury, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Sept. 6, 1958 | 22c. NAME OF CEMETERY OR CREMATORY St. Johns Church Cemetery | 22d. LOCATION (City, town, or county) Powellville, Maryland (State) _____ |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANYY *SALISBURY MARYLAND ADDRESS _____ | | 24a. REC'D BY REGISTRAR SEP 8 58 DATE _____ | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR OR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10714

CERTIFICATE OF DEATH

Reg. Dist. No.

10709

| | | | |
|---|-------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY <u>W. COMICO</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BERLIN</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>PEIX GENERAL HOSPITAL</u> | | d. STREET ADDRESS <u>315 BAY ST.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>CHARLES WILLIAM KIELMAN</u> | | 4. DATE OF DEATH <u>SEPTEMBER 21 1958</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>OCT. 10, 1897</u> |
| 9. AGE (In years lost birthday) <u>60</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | 11. IF UNDER 24 HRS Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MERCHANT</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN STORE</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>PORTSMOUTH, OHIO</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>JOHN KIELMAN</u> | | 14. MOTHER'S MAIDEN NAME <u>SOPHIA BEUMLER</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give year or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>211-01-7156</u> | |
| 17. INFORMANT <u>MRS. C.W. KIELMAN</u> | | Address <u>BERLIN MD</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid Hemorrhage</u> DUE TO <u>Arteriosclerotic Cerebrovascular Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Hypertensive Cardio-vascular Disease</u> (b) <u>Hypertensive Cardio-vascular Disease</u> (c) <u>Hypertensive Cardio-vascular Disease</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hrs</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Alcoholism</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept 21, 1958</u> , to <u>Sept 21, 1958</u> , that I lost saw the deceased alive on <u>Sept 21, 1958</u> , and that death occurred at <u>3:30 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Thomas C. Hilgert, M.D.</u> | | ADDRESS (Street, city or town, state) <u>Pine Bluff Road</u> DATE SIGNED <u>9/21/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Salisbury, Md.</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>9/25/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN</u> | | 22d. LOCATION (City, town, or county) (State) <u>BERLIN MD</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Anna A. Burboye</u> | | ADDRESS <u>Berlin Md</u> | |
| 24a. REC'D BY REGISTRAR <u>SEP 26 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10742

CERTIFICATE OF DEATH

Reg. Dist. No.

10710

| | | | | | | | |
|--|------------------------------------|--|---|---|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Eden R.F.D # 2 | | | | c. LENGTH OF STAY IN 1b | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Peninsula General Hospital | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| NAME OF DECEASED (Type or print) Richard D. King | | | | 4. DATE OF DEATH Month Sept. Day 23 Year 1958 | | | |
| 5. SEX male | 6. COLOR OR RACE colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH August 8, 1910 | | 9. AGE (In years last birthday) 48 yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) laborer | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) Allen | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Ernest King | | | | 14. MOTHER'S MAIDEN NAME Ida Dixon | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no | | 16. SOCIAL SECURITY NO. 213*14*7500 | | 17. INFORMANT Ernest King Address Route 2 Eden | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Memio 216X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Tuberculosis of Kidneys DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH days yr - | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 9-22 , 19 58 , to 9-23 , 19 58 , that I last saw the deceased alive on 9-23 , 19 58 , and that death occurred at 11 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 407 Camden Ave Salisbury Md. DATE SIGNED 9-25-58 | | | | | | | |
| ACTUAL SIGNATURE Earl L. Rye M.D. | | | | | | | |
| PHYSICIAN'S NAME (Type) Earl L. Rye | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) burial | | 22b. DATE THEREOF Sept. 28, 58 | | 22c. NAME OF CEMETERY OR CREMATORY Green Acres | | 22d. LOCATION (City, town, or county) (State) Salisbury Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Clinton F. Stewart ADDRESS West Road Salisbury Md. | | | | 24a. REC'D BY REGISTRAR DATE SEP 29 '58 | | 24b. REGISTRAR'S SIGNATURE C. L. S. Thoms | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

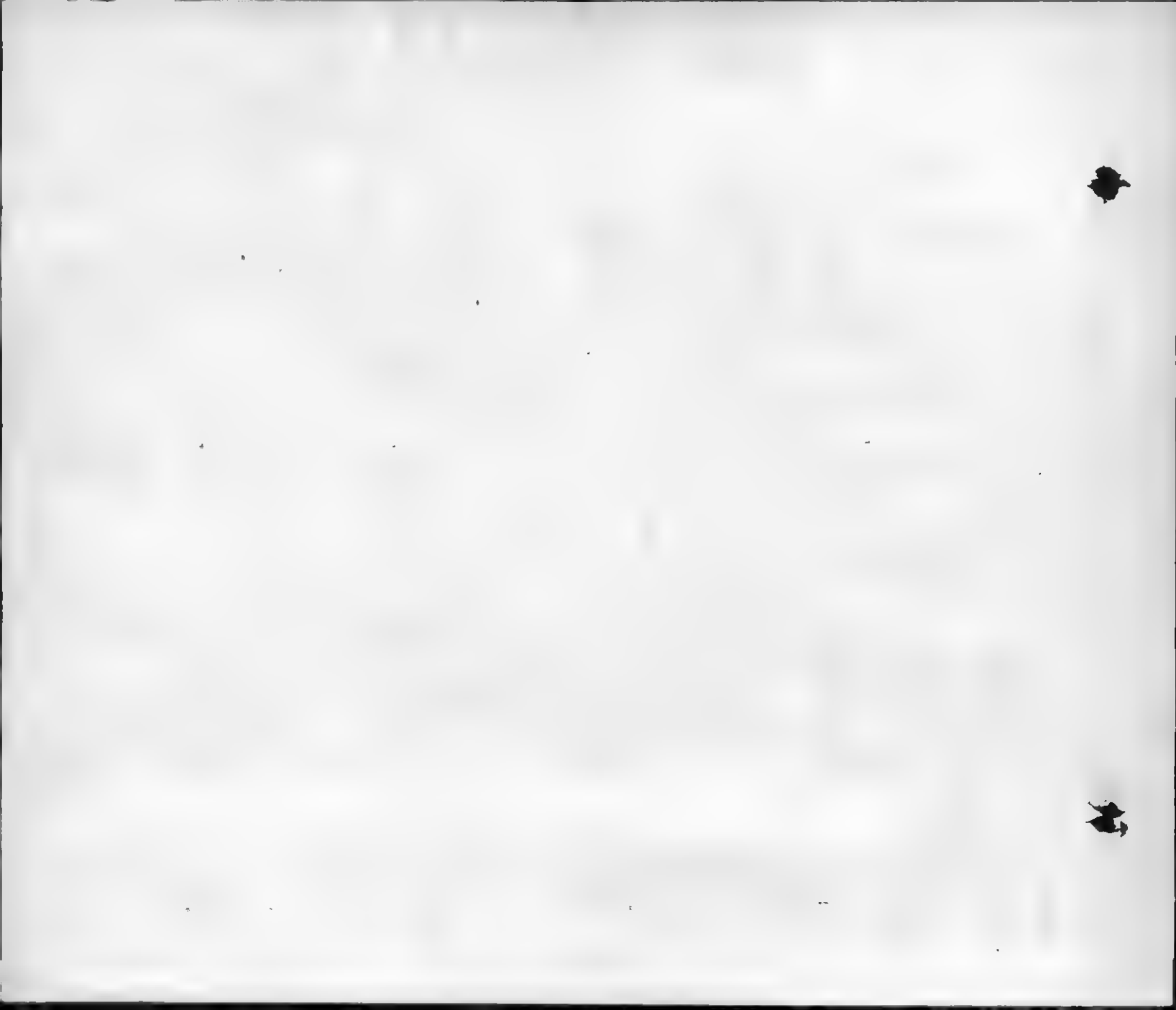
10743

CERTIFICATE OF DEATH

Reg. Dist. No.

10711

| | | | | | | | |
|---|-------------------------------------|---|--|---|--|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Delmar | | | | c. LENGTH OF STAY IN 1b 87 yrs | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 101 Pine Street | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Robert Middle Hitch Last Lowe | | | | 4. DATE OF DEATH Month Sept. Day 15 Year 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Dec. 14, 1870 | 9. AGE (In years last birthday) 87 yrs | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Merchant | | 10b. KIND OF BUSINESS OR INDUSTRY Ladies Merchandise | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? USA | |
| 13. FATHER'S NAME James Lowe | | | | 14. MOTHER'S MAIDEN NAME Hettie Hearn | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO 212-18-6081 | | 17. INFORMANT Ethel Smith, Delmar, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Thrombosis 792X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arterio Sclerosis DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 24 hrs | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Hour a. m. p. m. 19 | Month 14 | Day 14 | Year 19 58 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept 10 19 58 , to Sept 15 19 58 , that I last saw the deceased alive on Sept 14 19 58 , and that death occurred at M , from the causes and on the date stated above. ADDRESS (Street, city or town, state) Delmar, Del. DATE SIGNED Sept 17 - 58 | | | | | | | |
| ACTUAL SIGNATURE S. H. Lynch | | M. D. Delmar, Del. | | | | | |
| PHYSICIAN'S NAME (Type) S. H. Lynch | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9-17-58 | 22c. NAME OF CEMETERY OR CREMATORY Mt. Olive | | 22d. LOCATION (City, town, or county) (State) Delmar, Del. | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE H. S. Panel Co. Delmar, Del. | | | | 24a. REC'D BY REGISTRAR SEP 18 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kram | |



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10712

Reg. Dist. No.

10715

| | | | |
|--|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Virginia</u> b. COUNTY <u>Accomack</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chincoteague</u> | |
| c. LENGTH OF STAY IN 1b <u>4 Days</u> | | d. STREET ADDRESS <u>Oak Hall Piney Island</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Salisbury-Peninsula General</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Wyle</u> | First Middle Last <u>Maddox, Jr.</u> | 4. DATE OF DEATH | Month <u>9-</u> Day <u>9-</u> Year <u>19 58</u> |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>May 11, 1941</u> |
| 9. AGE (In years last birthday) <u>17</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Virginia</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Wyle Maddox Sr.</u> | | 14. MOTHER'S MAIDEN NAME <u>Luella Bowden</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>230-50-383</u> | |
| 17. INFORMANT <u>Wyle Maddox Sr.</u> | | Address <u>Chincoteague, Virginia</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Sub-dural hemorrhage</u> 4 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>4</u> DUE TO (c) | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Interval between onset and death 4 days</u> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Injured in a tackle during high school football practice</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>9-5-58</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Schoolyard</u> 20f. (City or town) <u>Chincoteague</u> (County) <u>Va.</u> (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Earl L. Royer</u> | | DATE SIGNED <u>9-13-58</u> | |
| EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>Sept. 12, 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Downing Cemetery</u> | 22d. LOCATION (City, town, or county) <u>Oak Hall, Virginia</u> (State) |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Selzer</u> | | 24. REC'D BY REGISTRAR <u>SEP 26 '58</u> 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be completed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 22 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10716

CERTIFICATE OF DEATH

10713

Reg. Dist. No.

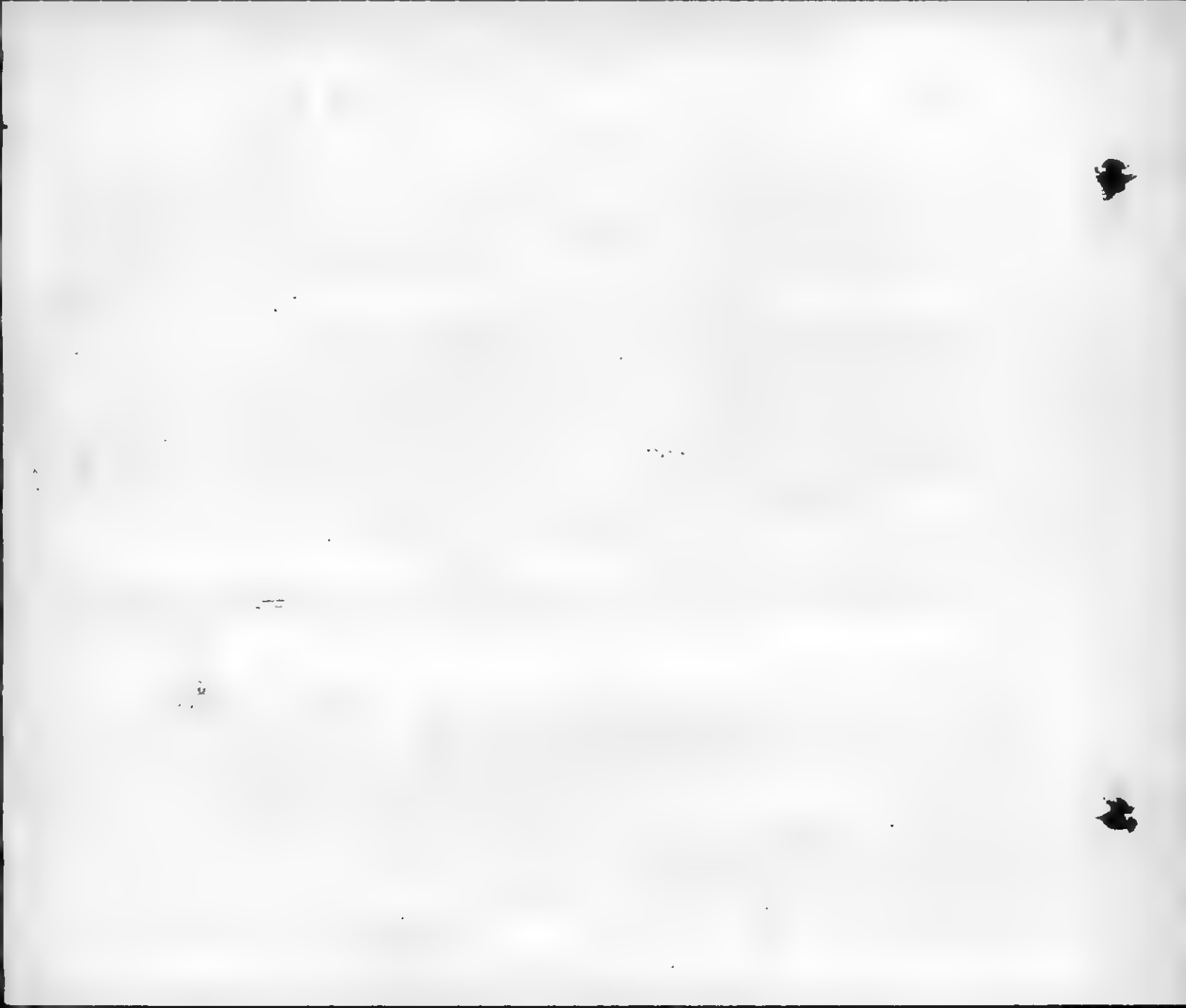
| | | | |
|--|---------------------------------|---|-----------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Stockton, Md.</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u> | | d. STREET ADDRESS <u>R.F.D. I Bx. 101</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>L. uvenia</u> Middle <u>Marshall</u> Last <u>Marshall</u> | | 4. DATE OF DEATH Month <u>September</u> Day <u>14</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Col.</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>9-7-58</u> |
| 9. AGE (In years last birthday) yrs. <u>7</u> | | 10. IF UNDER 1 YEAR Months <u>7</u> Days <u>7</u> Hours <u>7</u> Min <u>7</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Infant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Frank Garfield Marshall</u> | | 14. MOTHER'S MAIDEN NAME <u>Hattie H. Fisher</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Frank G. Marshall</u> | | Address <u>Stockton, Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Anoxia + hyperoxia</u> DUE TO (c) <u>atelectasis - left lung</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>1 hr</u> <u>2 days</u> <u>2 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>19</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9/13</u> , 1958, to <u>9/14</u> , 1958, that I last saw the deceased alive on <u>9/14</u> , 1958, and that death occurred at <u>12:30 P</u> M, from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>William C. Morgan</u> M.D. | | ADDRESS (Street, city or town, state) <u>Medical Center Salisbury Md</u> | |
| PHYSICIAN'S NAME (Type) <u>William C. Morgan</u> | | DATE SIGNED <u>9/14/58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>9-16-58</u> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Mount Hope Cem.</u> | | 22d. LOCATION (City, town, or county) (State) <u>Stockton, Md.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Edgar Wharton - New Church, Va.</u> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR <u>SEP 22 '58</u> | | DATE | |
| 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hinde</u> | | DATE | |

4000440XVI



MEDICAL CERTIFICATION

VS A15 (4)
15M 10/57



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

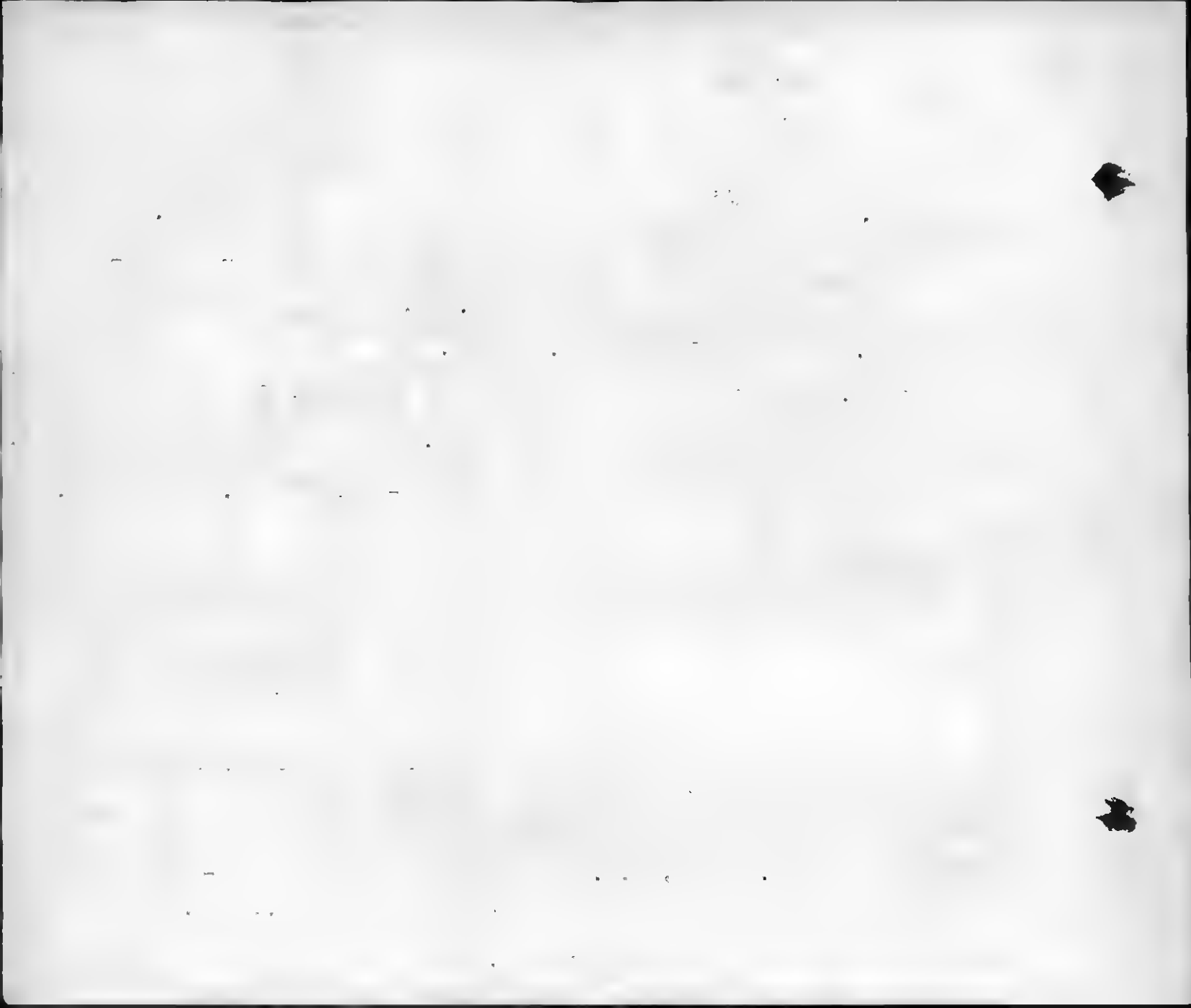
10715

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed in the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Brown St.</u> | | d. STREET ADDRESS <u>755 Charing Cross Rd.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>Leroy</u> Middle <u>Burton</u> Last <u>Miller</u> | | 4. DATE OF DEATH Month <u>9-</u> Day <u>22-</u> Year <u>19 58</u> | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Oct. 24, 1917</u> 40 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sales Mgr.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Filbert Marg.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Md.</u> | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Mark S. Miller</u> | | 14. MOTHER'S MAIDEN NAME <u>Evelyn Hoshall</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Yes WW II</u> | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT <u>Laverne T. Miller</u> | | Address <u>755 Charing Cross Rd.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Sub-arachnoid hemorrhage-spontaneous.</u> <u>350 X</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (a), stating the underlying cause last. (c) _____ DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <u>Sudden.</u> | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>o. m. p. m.</u> <u>19</u> | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Earl L. Royer</u> | | DATE SIGNED <u>9-23-58</u> | |
| EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL CREMATION, REMOVAL, (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>9-26-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Baltimore National</u> | 22d. LOCATION (City, town, or county) (State) <u>Balto., Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Howard H. Hubbard</u> | | 24a. REC'D BY REGISTRAR DATE <u>SEP 25 '58</u> | |
| ADDRESS <u>4107 Wilkens Ave.</u> | | 24b. REGISTRAR'S SIGNATURE <u>C. L. S. Kraw</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,
page 3 should be attached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

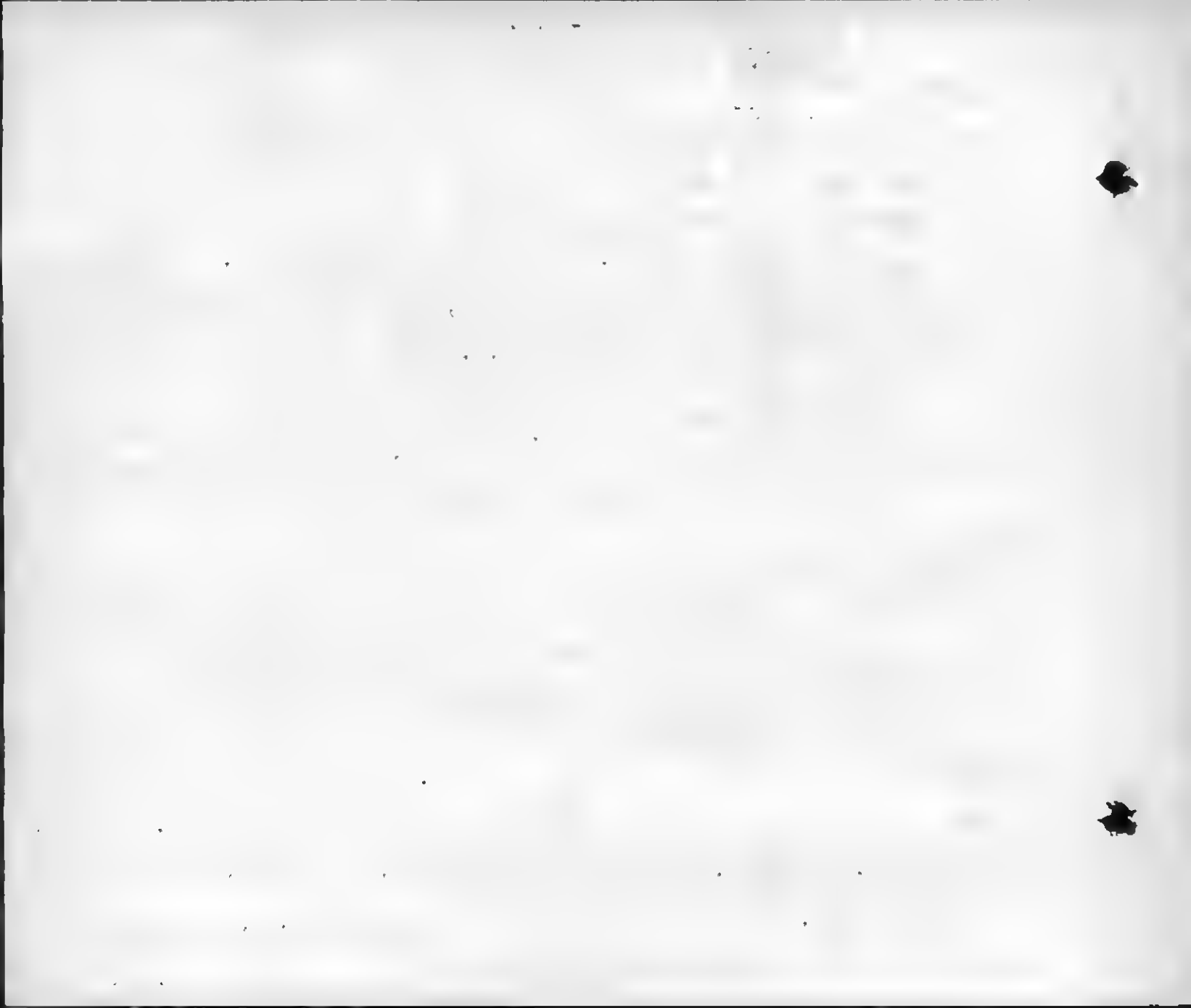
10719

CERTIFICATE OF DEATH

10716

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Salisbury 1</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. LENGTH OF STAY IN 1b | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsular General Hospital</u> | | | | d. STREET ADDRESS <u>604 Wicomico</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Della B. Mills</u> | | | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>19th</u> Year <u>1958</u> | | | |
| 5. SEX <u>Female</u> | | 6. COLOR OR RACE <u>White</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>July 18, 1883</u> | |
| 9. AGE (In years last birthday) <u>75</u> yrs | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home</u> | | 11. BIRTHPLACE (State or foreign country) <u>R.D.# Snow Hill Md</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U S A</u> | |
| 13. FATHER'S NAME <u>Isaac James Bowen</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Pricella Petitt</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT <u>Mr. Lue Mills (Husband)</u> Address <u>604 Wicomico St Salisbury, Maryland</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gastrointestinal Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Cerebral Vascular Thrombosis</u> DUE TO (c) <u>Arteriosclerotic heart disease</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9-9-1958</u> to <u>9-19-1958</u> , that I last saw the deceased alive on <u>9-9-1958</u> , and that death occurred at <u>11:20</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Sept. 19th 1958</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | | | 22b. DATE THEREOF <u>Sept. 22/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Parsons Cemetery</u> | |
| 22d. LOCATION (City, town, or county) <u>Salisbury, Maryland</u> | | | | 22e. (State) | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>HOLLOWAY & COMPANY</u> ADDRESS <u>SALISBURY MARYLAND</u> | | | | 24a. REC'D BY REGISTRAR <u>SEP 22 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur J. Hines</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10720

CERTIFICATE OF DEATH

10717

Reg. Dist. No.

| | | | |
|--|---------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution on Residence before admission) a. STATE <u>Del.</u> b. COUNTY <u>Sussex</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural Millsboro</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u> | | d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Elmer</u> Middle <u>Morris</u> Last <u>Morris</u> | | 4. DATE OF DEATH Month <u>September</u> Day <u>21</u> Year <u>1958</u> | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>col.</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/12/1890</u> |
| 9. AGE (In years last birthday) <u>68</u> yrs | | IF UNDER 1 YEAR Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMING</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>SELF</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>DEL.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u> | |
| 13. FATHER'S NAME <u>Joseph Morris</u> | | 14. MOTHER'S MAIDEN NAME <u>Hester Jackson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) <u>no</u> | | 16. SOCIAL SECURITY NO <u>222-24-5677</u> | |
| 17. INFORMANT <u>EVA M. Morris</u> | | Address <u>Millsboro</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). <u>Chronic Pyelonephritis</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Chronic Pyelonephritis</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Pyelonephritis</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 yrs</u> <u>Chronic</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at <u>2:15</u> A. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Frank Wilson</u> | | M.D. <u>Salisbury Md.</u> DATE SIGNED <u>Sept. 21, 1958</u> | |
| PHYSICIAN'S NAME (Type) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>9/24/59</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>CHURCH OF CHRIST</u> | | 22d. LOCATION (City, town, or county) (State) <u>HARBENSON - DEL</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Ronald James Millsboro Del.</u> | | 24a. REC'D BY REGISTRAR DATE <u>SEP 29 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Ernest L. Evans</u> | | | |



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10721

CERTIFICATE OF DEATH

10718

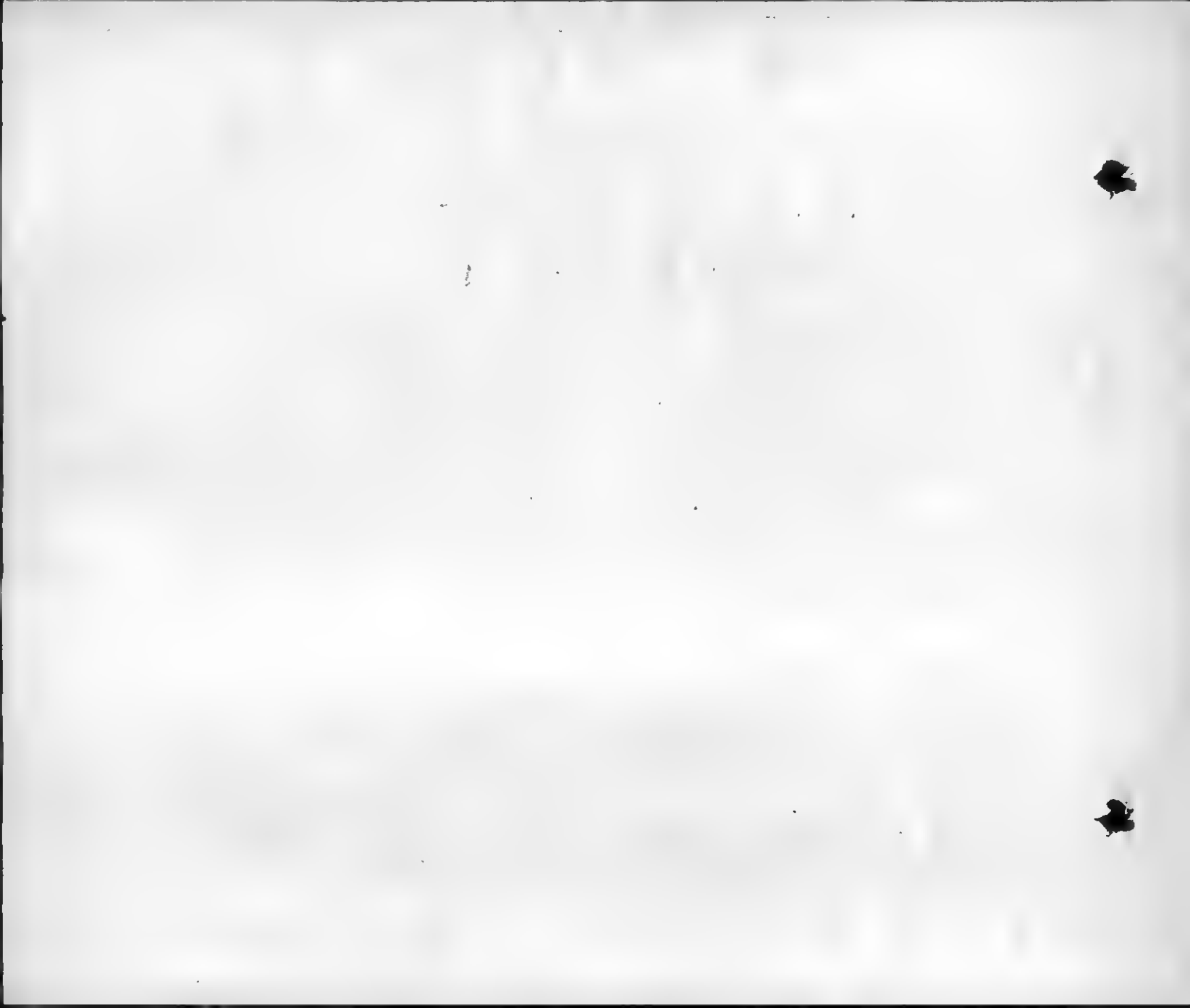
Reg. Dist. No.

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY c. LENGTH OF STAY IN b 4 DAYS d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL | | 2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE MARYLAND b. COUNTY Wicomico c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 12 SALISBURY d. STREET ADDRESS JOHN B. PARSONS HOME e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) MARGARET First Middle Last POLLITT | | 4. DATE OF DEATH Month Day Year SEPTEMBER 12 1958 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/29/1879 9. AGE (In years last birthday) 79 yrs. Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | 11. BIRTHPLACE (State or foreign country) MARYLAND |
| 12. CITIZEN OF WHAT COUNTRY? U. S. A. | | 13. FATHER'S NAME THOMAS H RICHARDSON | |
| 14. MOTHER'S MAIDEN NAME MARGARET BOWEN | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | |
| 16. SOCIAL SECURITY NO — | | 17. INFORMANT JOHN B. PARSON HOME SALISBURY MD Address | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Intoxication DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Prolapsed acute alcoholism DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 1958 to 9-12 , 19 58 , that I last saw the deceased alive on 9-11 , 19 58 , and that death occurred at 3:17 A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Dr. Philip A. Insley 114 E MAIN ST, SALISBURY, MD. 9-12-58 | | | |
| ACTUAL SIGNATURE Dr. Philip A. Insley | | PHYSICIAN'S NAME (Type) Dr. Philip A. Insley 114 E MAIN ST, SALISBURY, MD. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 9/15/1958 | 22c. NAME OF CEMETERY OR CREMATORY WHITCOAT CEMETERY | 22d. LOCATION (City, town, or county) (State) SALISBURY, MARYLAND |
| 23. FUNERAL DIRECTOR'S SIGNATURE Hill & Johnson SALISBURY, MD. ADDRESS Norman & Barker | | 24a. REC'D BY REGISTRAR DATE SEP 17 '58 | 24b. REGISTRAR'S SIGNATURE Arthur S. Evans |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death; Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10722

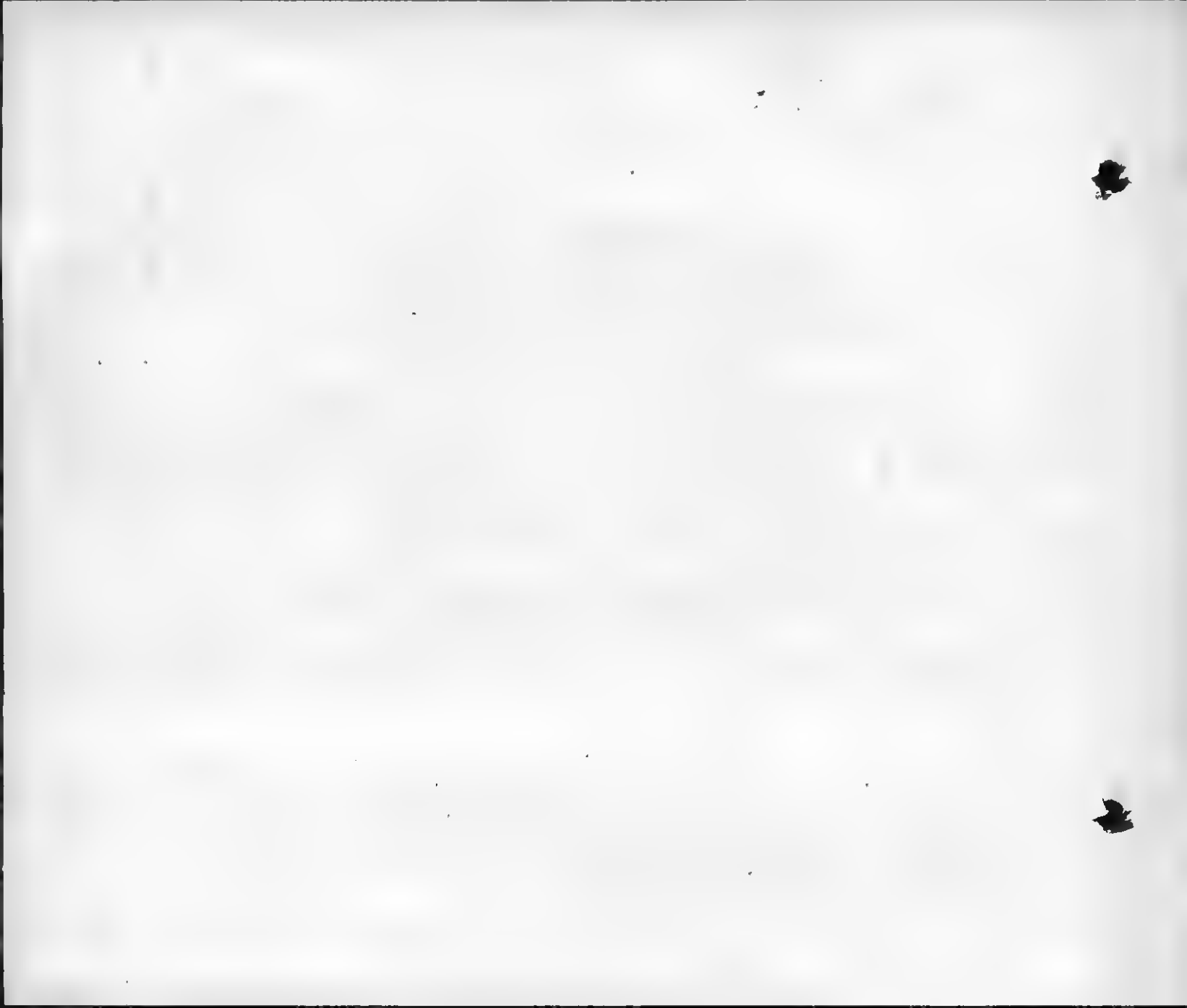
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Maryland b. COUNTY Worcester | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Snow Hill | |
| c. LENGTH OF STAY IN b. 5 mo. 7 days | | d. STREET ADDRESS Market Street | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Georgeanna Middle Hales Last Richardson | | 4. DATE OF DEATH Month September Day 22 Year 1958 | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 10, 1874 |
| 9. AGE (In years lost birthday) 84 yrs. | | 10. IF UNDER 1 YEAR: Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME John Stewart Hales | | 14. MOTHER'S MAIDEN NAME Henrietta Hoosier | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unknown | | 16. SOCIAL SECURITY NO. None | |
| 17. INFORMANT Hospital Records, Salisbury, Maryland | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). Arteriosclerotic cardiovascular disease 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerosis, generalized DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH Years Years | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral thrombosis | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from April 14, 1958 , to Sept. 22, 1958 , that I last saw the deceased alive on Sept. 22, 1958 , and that death occurred at 9:30 A.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE L. V. Maldve | | ADDRESS (Street, city or town, state) Deer's Head State Hospital | |
| PHYSICIAN'S NAME (Type) L. V. Maldve, M. D. | | DATE SIGNED 9/22/58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Sept. 24/58 | |
| 22c. NAME OF CEMETERY OR CREMATORY Methodist | | 22d. LOCATION (City, town, or county) (State) Snow Hill, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Norman F. Williams | | ADDRESS Snow Hill, Md. | |
| 24a. REC'D BY REGISTRAR SEP 24 58 | | 24b. REGISTRAR'S SIGNATURE Arthur L. Kious | |

MEDICAL CERTIFICATION

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be obtained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 are to be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

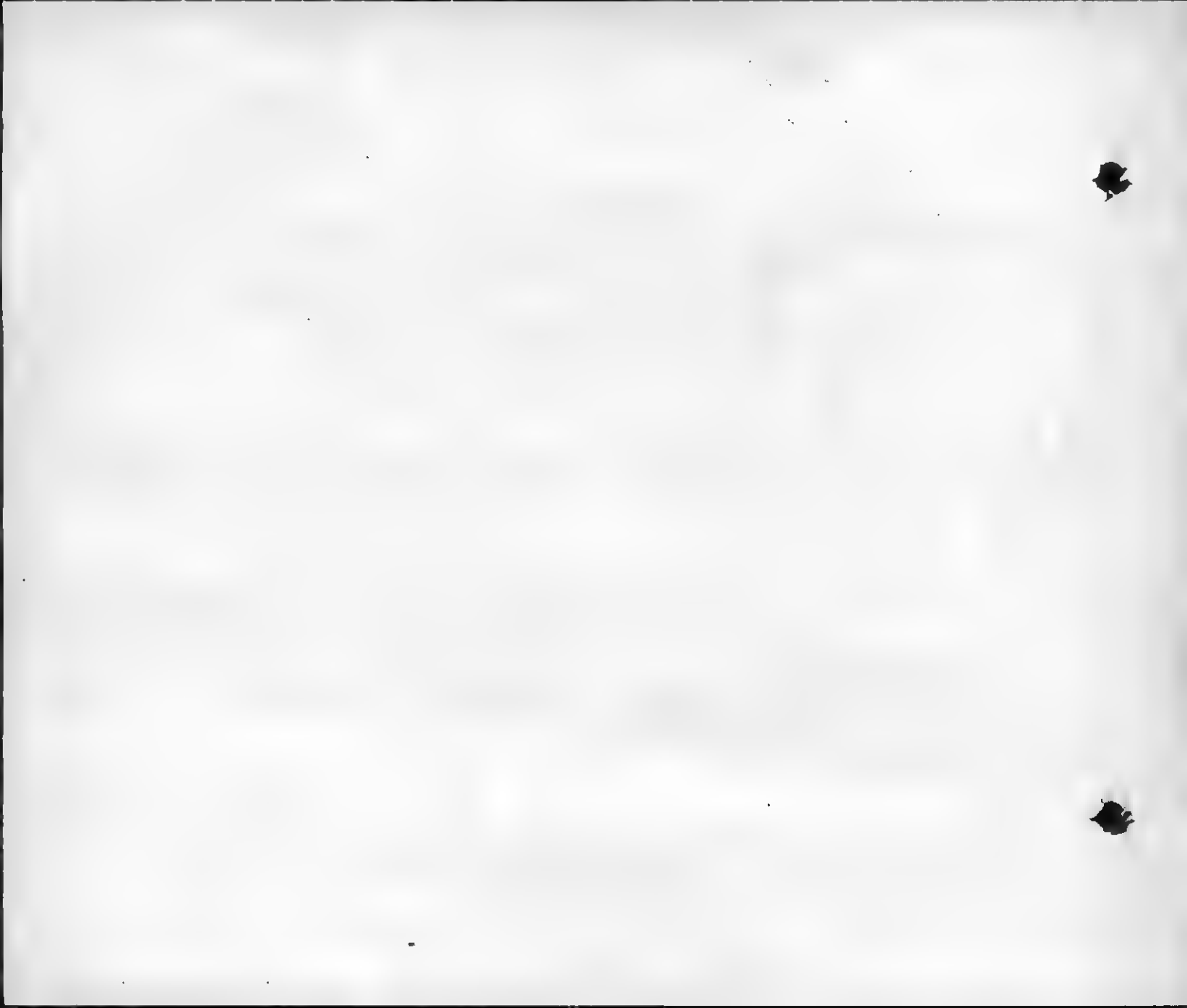
10723

CERTIFICATE OF DEATH

Reg. Dist. No.

10720

| | | | |
|--|------------------------------------|---|-------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>Maryland</u> b. COUNTY | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cavan City</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Annville General Hospital</u> | | d. STREET ADDRESS <u>306 Somerset Ave.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>Robbins</u> Last <u>Robbins</u> | | 4. DATE DEATH <u>September 17</u> 19 <u>58</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>1-2-1903</u> |
| 9. AGE (In years last birthday) <u>55</u> yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Lunch Room Operator Restaurant</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Obe Quillen</u> | | 14. MOTHER'S MAIDEN NAME <u>Mary E. Pitts</u> | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service) <u>NO</u> | | 16. SOCIAL SECURITY NO <u>280-22-8970</u> | |
| 17. INFORMANT <u>Sheldon DENNIS, Berlin, Md. Rt #1</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> <u>44.3X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Cardiovascular Disease</u> (c) <u>6-8 yrs</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>6 days</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>9/16</u> 19 <u>58</u> to <u>9/17</u> 19 <u>58</u> , that I last saw the deceased alive on <u>9/17</u> 19 <u>58</u> , and that death occurred at <u>8:10</u> P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Rufus S. Gardner Jr.</u> M.D. | | ADDRESS (Street, city or town, state) <u>Pinebluff Rd. Salisbury, Md</u> | |
| PHYSICIAN'S NAME (Type) <u>RUFUS S. GARDNER JR.</u> | | DATE SIGNED <u>9/17/58</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>9-22-58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>BERLIN, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J. F. Stewart FUNERAL HOME, Salisbury, Md</u> | | ADDRESS | |
| 24a. REC'D BY REGISTRAR <u>SEP 24 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Chas. S. Kenna</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

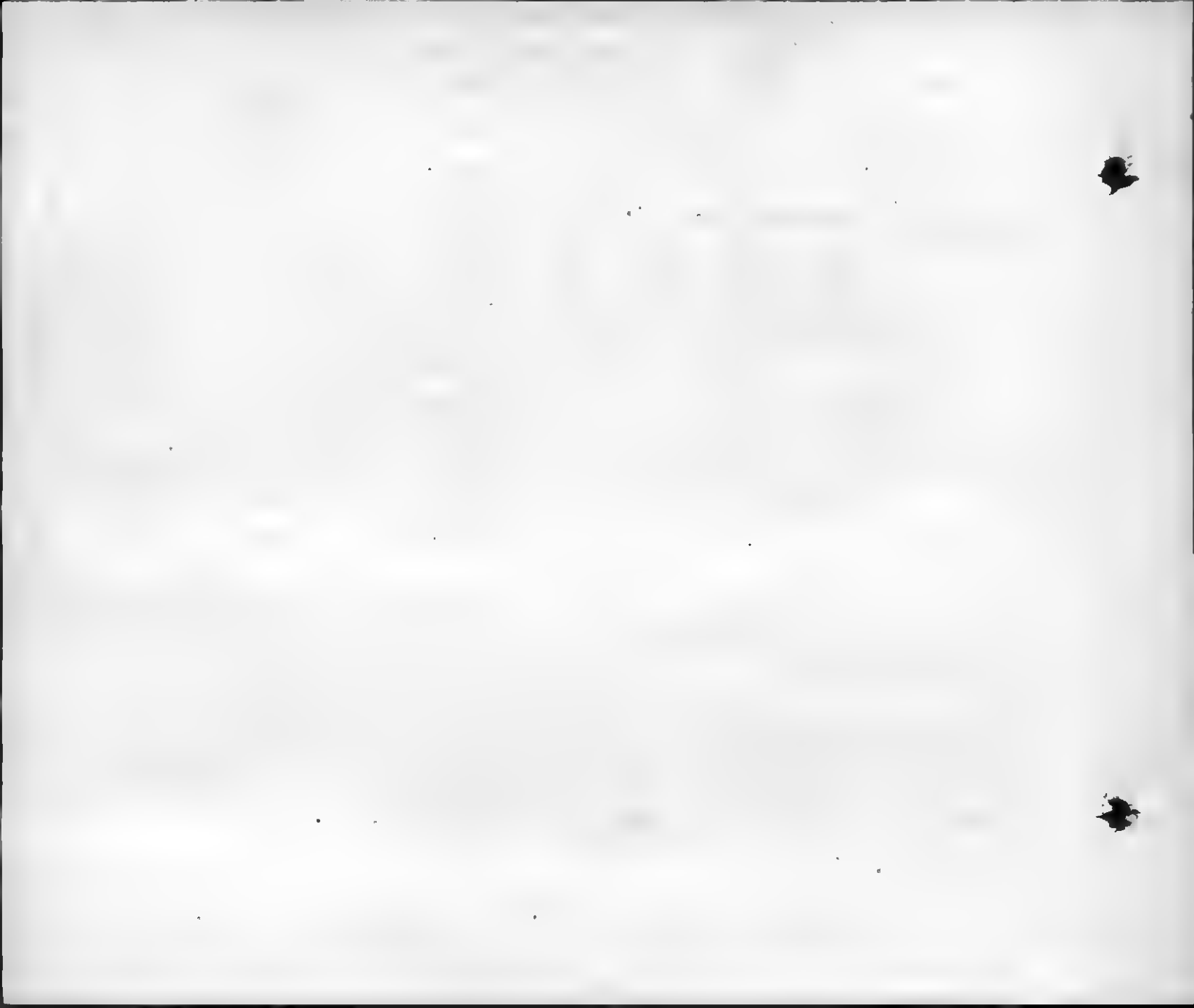
10724

CERTIFICATE OF DEATH

10721

Reg. Dist. No.

| | | | |
|---|-------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE Md. b. COUNTY Wicomico | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Calisbury | | c. LENGTH OF STAY IN TB 10 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Springhill Sanitarium, Inc. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Guy Middle Harvey Last Rodman | | 4. DATE OF DEATH Month Sept. Day 17 Year 1958 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 8-7-1870 |
| 9. AGE (In years last birthday) 88 yrs | | 10. IF UNDER 1 YEAR Months 1 Days 10 | 11. IF UNDER 24 HRS Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) American Cotton Oil Co. Agent | | 10b. KIND OF BUSINESS OR INDUSTRY Purchasing | |
| 11. BIRTHPLACE (State or foreign country) Ill. | | 12. CITIZEN OF WHAT COUNTRY? U. S. A. | |
| 13. FATHER'S NAME Washington Rodman | | 14. MOTHER'S MAIDEN NAME Blackwell | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO ---- | |
| 17. INFORMANT Mrs Guy Rodman, Witehaven, Md. | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY Occlusion 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic Heart Disease DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH 10 years | |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 15 Oct. 1957 to Sept 17, 1958 , that I last saw the deceased alive on 17 Sept. 1958 , and that death occurred at 4:30 A. M. from the causes and on the date stated above ADDRESS (Street, city or town, state) Nanticoke, Md. DATE SIGNED | | | |
| ACTUAL SIGNATURE Richard H. Saunders M.D. | | | |
| PHYSICIAN'S NAME (Type) Dr. Richard H. Saunders | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9/19/58 | 22c. NAME OF CEMETERY OR CREMATORY Flushing Cem, | 22d. LOCATION (City, town, or county) (State) Flushing, N.Y. |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. J. Messick | | 24a. REC'D BY REGISTRAR DATE SEP 22 '58 | |
| ADDRESS Bivalve, Maryland | | 24b. REGISTRAR'S SIGNATURE James L. Hume | |



10725

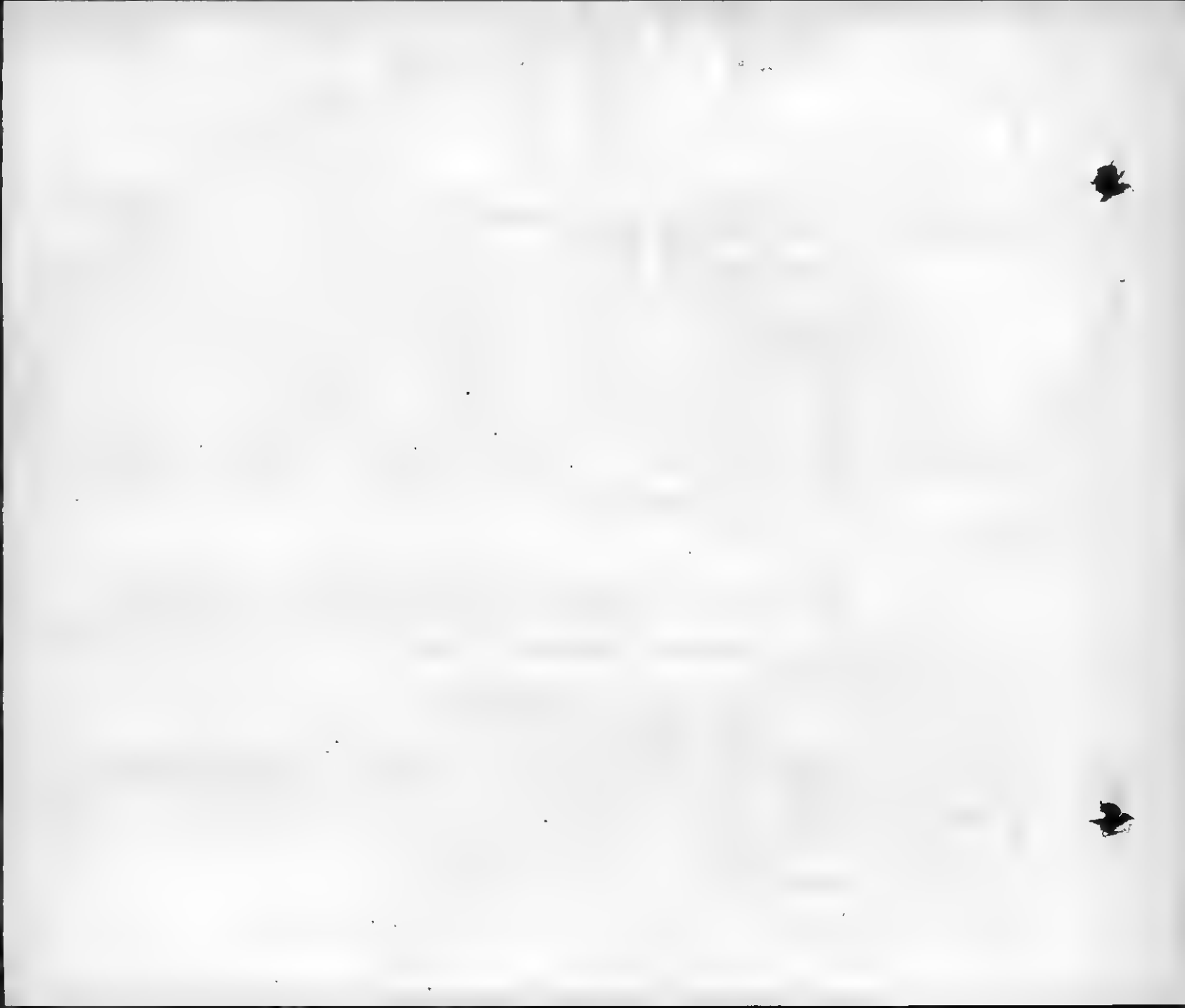
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>Accomack</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chincoteague</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula Memorial Hospital</u> | | d. STREET ADDRESS <u>123 East Kearsarge Circle</u> | |
| 3. NAME OF DECEASED (Type or print) <u>JEAN ANN</u> | | 4. DATE OF DEATH <u>September 24 1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>SEPT 24, 1958</u> |
| 9. AGE (In years last birthday) <u>1</u> yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS Months <u>1</u> Days <u>59</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Joseph A. Sabol</u> | | 14. MOTHER'S MAIDEN NAME <u>ANN FUKAT</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> | | 16. SOCIAL SECURITY NO. <u>—</u> | |
| 17. INFORMANT <u>J. A. Sabal - Chincoteague Va</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>752x</u> DUE TO <u>Heart failure, Chincoteague</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>—</u> DUE TO (c) <u>—</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u> | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Sept 1958</u> to <u>Sept 24, 1958</u> , that I last saw the deceased alive on <u>Sept 12, 1958</u> , and that death occurred at <u>12:00 A.M.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>J. H. Downing</u> M.D. | | ADDRESS (Street, city or town, state) <u>752 Chincoteague Island</u> DATE SIGNED <u>9/24/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Sabal</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>SEPT 27, 1958</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>DOWNING</u> | 22d. LOCATION (City, town, or county) (State) <u>OAK HALL VA</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>William B. Salzer</u> | | 24a. REC'D BY REGISTRAR <u>DATE OCT 1 '58</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hines</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



10726

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|--|--|---|--|--|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>DELAWARE</u> b. COUNTY <u>SUSSEX</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FRANKFORD</u> 46X ✓ | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>RAYMOND W. SAVAGE</u> | | | | 4. DATE OF DEATH <u>SEPTEMBER 15 1958</u> | | | |
| 5 SEX <u>MALE</u> | | 6. COLOR OR RACE <u>WHITE</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>5/6/1906</u> | |
| 9 AGE (In years last birthday) <u>52</u> yrs. | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER POULTRY</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>DELAWARE</u> | | 11 BIRTHPLACE (State or foreign country) <u>DELAWARE</u> | | 12 CITIZEN OF WHAT COUNTRY? <u>USA.</u> | |
| 13 FATHER'S NAME <u>THOMAS SAVAGE</u> | | | | 14. MOTHER'S MAIDEN NAME <u>EVA TYRE</u> | | | |
| 15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) | | 16. SOCIAL SECURITY NO. | | 17 INFORMANT <u>MRS. MAUDE SAVAGE FRANKFORD, DE.</u> Address | | | |
| 18. CAUSE OF DEATH {Enter only one cause per line for (a), (b), and (c).} PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> <u>331X</u> DUE TO (b) <u>Cerebral Atherosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Essential Hypertension</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>24 hr.</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | 19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o m. 19 p. m. | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| 20f. (City or town) | | | | 20g. (County) | | 20h. (State) | |
| 21. I certify that I attended the deceased from <u>Sept 14, 1958</u> to <u>Sept 15, 1958</u> that I last saw the deceased alive on <u>Sept 15, 1958</u> and that death occurred at <u>6:15 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>David Simon</u> M.D. | | | | DATE SIGNED <u>Sept 15, 1958</u> | | | |
| PHYSICIAN'S NAME (Type) | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>9/18/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>ROXANA CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>ROXANA DEL.</u> | |
| 23 FUNERAL DIRECTOR'S SIGNATURE <u>Watson & Gray Frankford Del.</u> ADDRESS | | | | 24a. REC'D BY REGISTRAR <u>SEP 24 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>William S. Simon</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

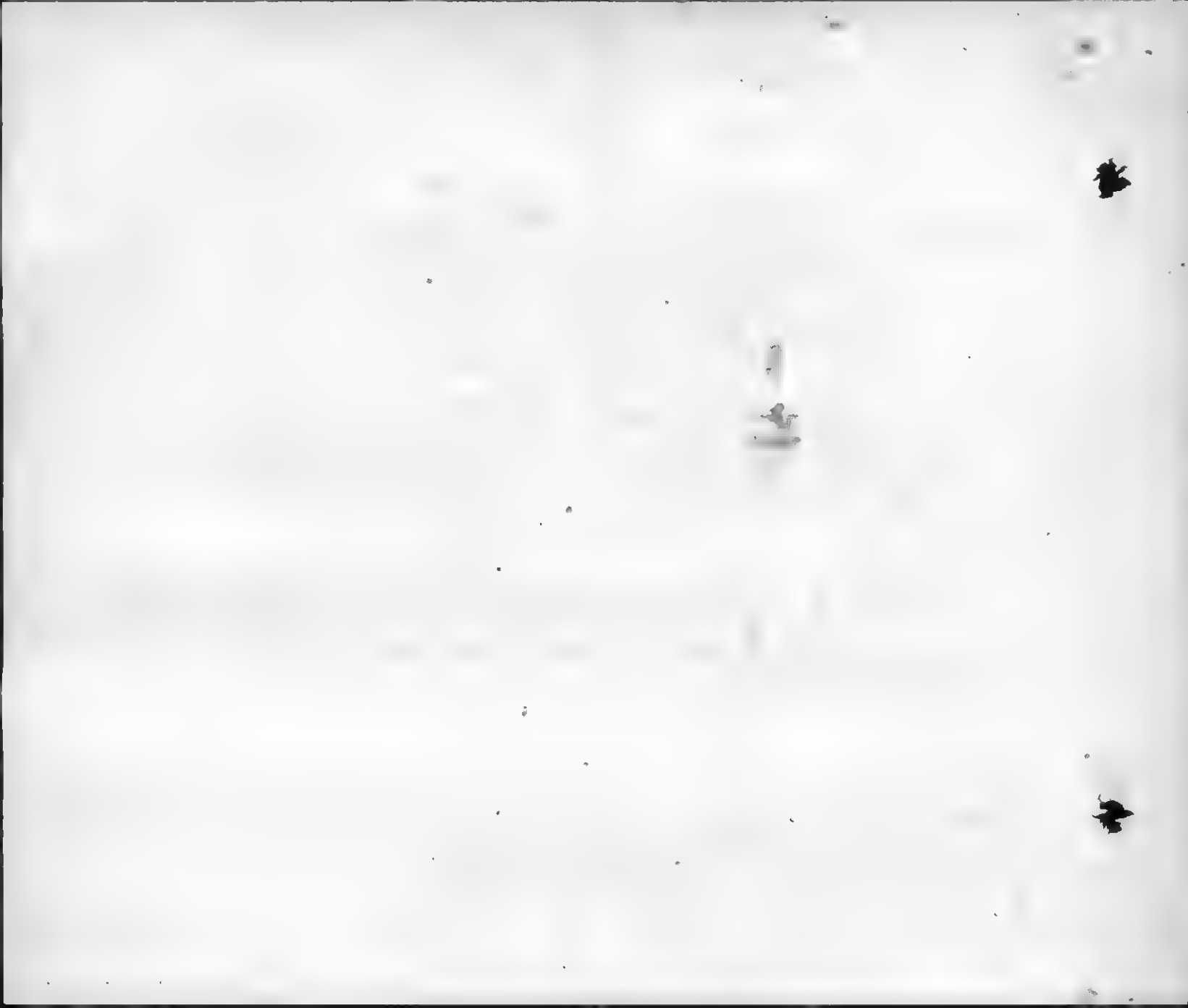
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CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|------------------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pocomoke City</u> | |
| c. LENGTH OF STAY IN 1b <u>4 DAYS</u> | | d. STREET ADDRESS <u>14 Second Street</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Ada</u> Middle <u>HARGIS</u> Last <u>Scott</u> | | 4. DATE OF DEATH Month <u>September</u> Day <u>4</u> Year <u>1958</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>FEB. 26, 1869</u> |
| 9. AGE (In years last birthday) <u>89</u> yrs | | 10. IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>WILLIAM THOMAS HARGIS</u> | | 14. MOTHER'S MAIDEN NAME <u>SARA ELIZABETH COSTEN</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | |
| 17. INFORMANT <u>MRS SARA S. DALLAS, Pocomoke City, Md.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>55871</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Insufficiency</u> (c) <u>Myocardial infarction</u> | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>8:30</u> , 19 <u>58</u> , to <u>9:17</u> , 19 <u>58</u> , that I last saw the deceased alive on <u>9:17</u> , 19 <u>58</u> , and that death occurred at <u>4:55</u> P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>H. P. Briete</u> | | DATE SIGNED <u>9-9-58</u> | |
| PHYSICIAN'S NAME (Type) <u>H. P. Briete</u> | | ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>9-9-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN CEMETERY Pocomoke City, Maryland</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Maryland</u> | | 24a. REC'D BY REGISTRAR <u>SEP 11 '58</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry H. Watson</u> | | 24b. REGISTRAR'S SIGNATURE <u>Cl. J. S. Thomas</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by a funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

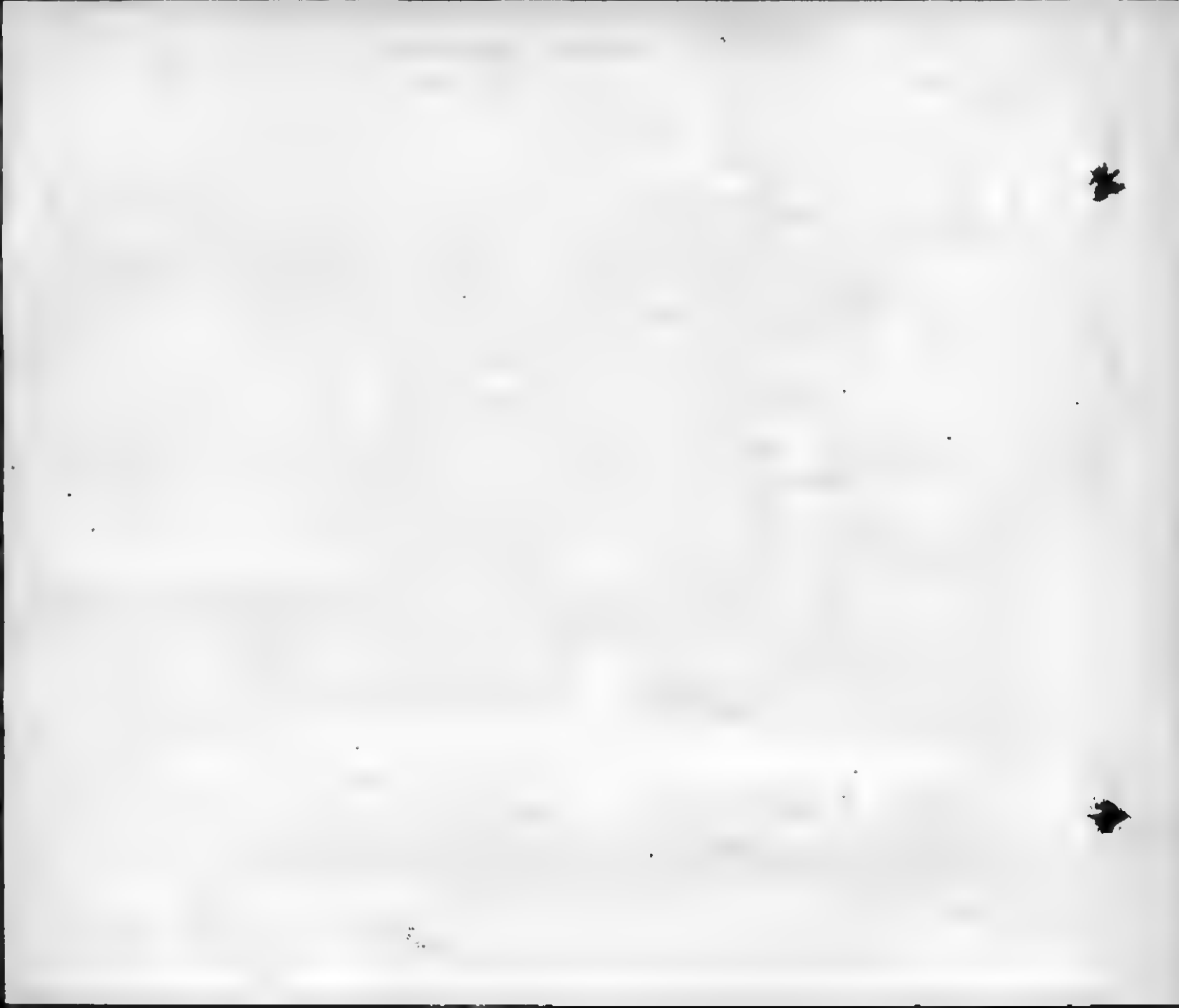
10728

CERTIFICATE OF DEATH

10725

Reg. Dist. No.

| | | | | | | | |
|---|--|--|--------------------------------------|--|--|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Salisbury, Wicomico</u> <u>MARYLAND</u> County | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Worcester</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | | c. LENGTH OF STAY IN IS <u>5 months</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Deer's Head State Hospital</u> | | | | d. STREET ADDRESS <u>Route #2</u> | | | |
| 3. NAME OF DECEASED (Type or print) First <u>Joseph</u> Middle <u>Burt</u> Last <u>Short</u> | | | | 4. DATE OF DEATH Month <u>Sept</u> Day <u>15</u> Year <u>19 58</u> | | | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Negro</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 1, 1877</u> | | 9. AGE (In years last birthday) <u>80</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>--</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>--</u> | | 11. BIRTHPLACE (State or foreign country) <u>Frankford, Delaware</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>George E. Short</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Martha Pickets</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Unk.</u> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <u>--</u> | | 17. INFORMANT Address <u>Deer's Head State Hospital Records, Salisbury,</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gastro intestinal hemorrhage due to</u> DUE TO <u>Intestinal malign neoplasm</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Unk.</u> DUE TO (c) <u>Unk.</u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs.</u> |
| PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Diabetes mellitus, Residual left hemiplegia, Arteriosclerosis</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.) <u>--</u> | | | | | |
| 20c. TIME OF INJURY Month <u>19</u> Day <u>19</u> Year <u>58</u> Hour a. m. p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>--</u> | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from <u>April 14, 19 58</u> , to <u>Sept. 15, 19 58</u> , that I last saw the deceased alive on <u>Sept. 15, 19 58</u> , and that death occurred at <u>2:20 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>G. Kosmahly</u> M.D. | | | | ADDRESS (Street, city or town, state) <u>Salisbury, Maryland</u> | | DATE SIGNED <u>9/15/58</u> | |
| PHYSICIAN'S NAME (Type) <u>G. Kosmahly, M.D.</u> | | | | Deer's Head State Hospital | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>9-19-58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>EVERGREEN CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>BERLIN, MARYLAND</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>J.E. Stewart</u> ADDRESS <u>FUNERAL HOME, SALISBURY, MD</u> | | | | 24a. REC'D BY REGISTRAR <u>SEP 22 1958</u> | | 24b. REGISTRAR'S SIGNATURE <u>--</u> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

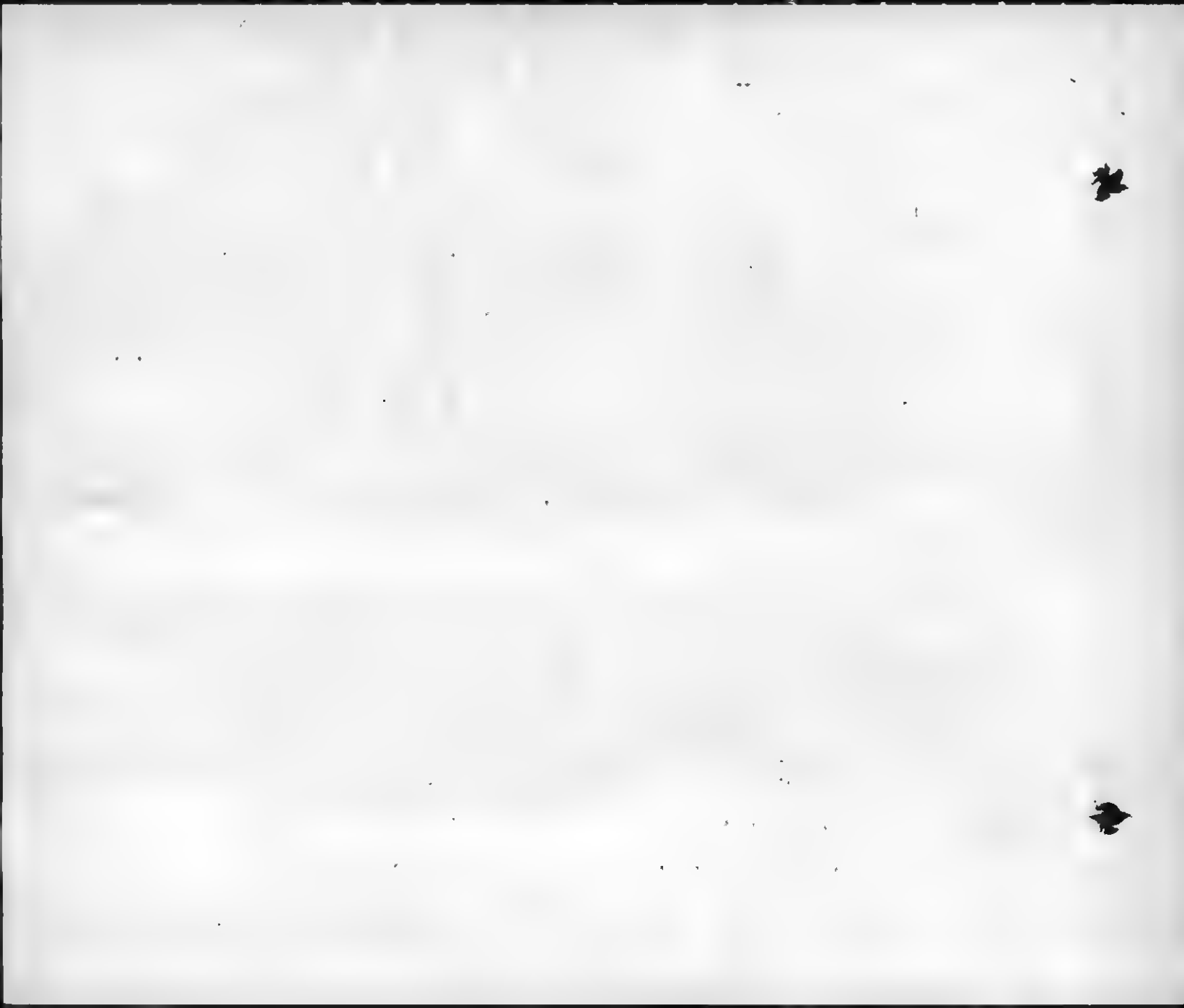
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10729

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution. Residence before admission) a. STATE Maryland b. COUNTY Baltimore City | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore | |
| c. LENGTH OF STAY IN 1b 82 days | | d. STREET ADDRESS 1807 Whitmore Avenue | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Inez Middle Flora Last Smith | | 4. DATE OF DEATH Month September Day 7 Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 12, 1927 |
| 9. AGE (In years last birthday) 31 yrs. | | IF UNDER 1 YEAR Months Days Hours Min | IF UNDER 24 HRS Months Days Hours Min |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (State or foreign country) Maryland |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | 13. FATHER'S NAME Lee, Hugh | |
| 14. MOTHER'S MAIDEN NAME Bagwell, Lucy | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Unk | |
| 16. SOCIAL SECURITY NO. | | 17. INFORMANT Address Hospital Records, Salisbury, Maryland | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Squamous cell Ca. of cervix uteri with generalized metastases DUE TO Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause last. (b) _____ DUE TO (c) _____ | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from June 17 19 58 , to September 7 19 58 , that I last saw the deceased alive on September 7 19 58 , and that death occurred at 9:15 P.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Dr. V. Juerman M.D. Deer's Head State Hospital 9/8/58 | | | |
| ACTUAL SIGNATURE Dr. V. Juerman | | PHYSICIAN'S NAME (Type) V. Juerman, M. D. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/11/58 | 22c. NAME OF CEMETERY OR CREMATORY mt Auburn |
| 22d. LOCATION (City, town, or county) (State) Baltimore Md. | | 24a. REC'D BY REGISTRAR DATE SEP 9 1958 | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Arlington S. Phillips | | 24b. REGISTRAR'S SIGNATURE J. L. Hines | |



FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

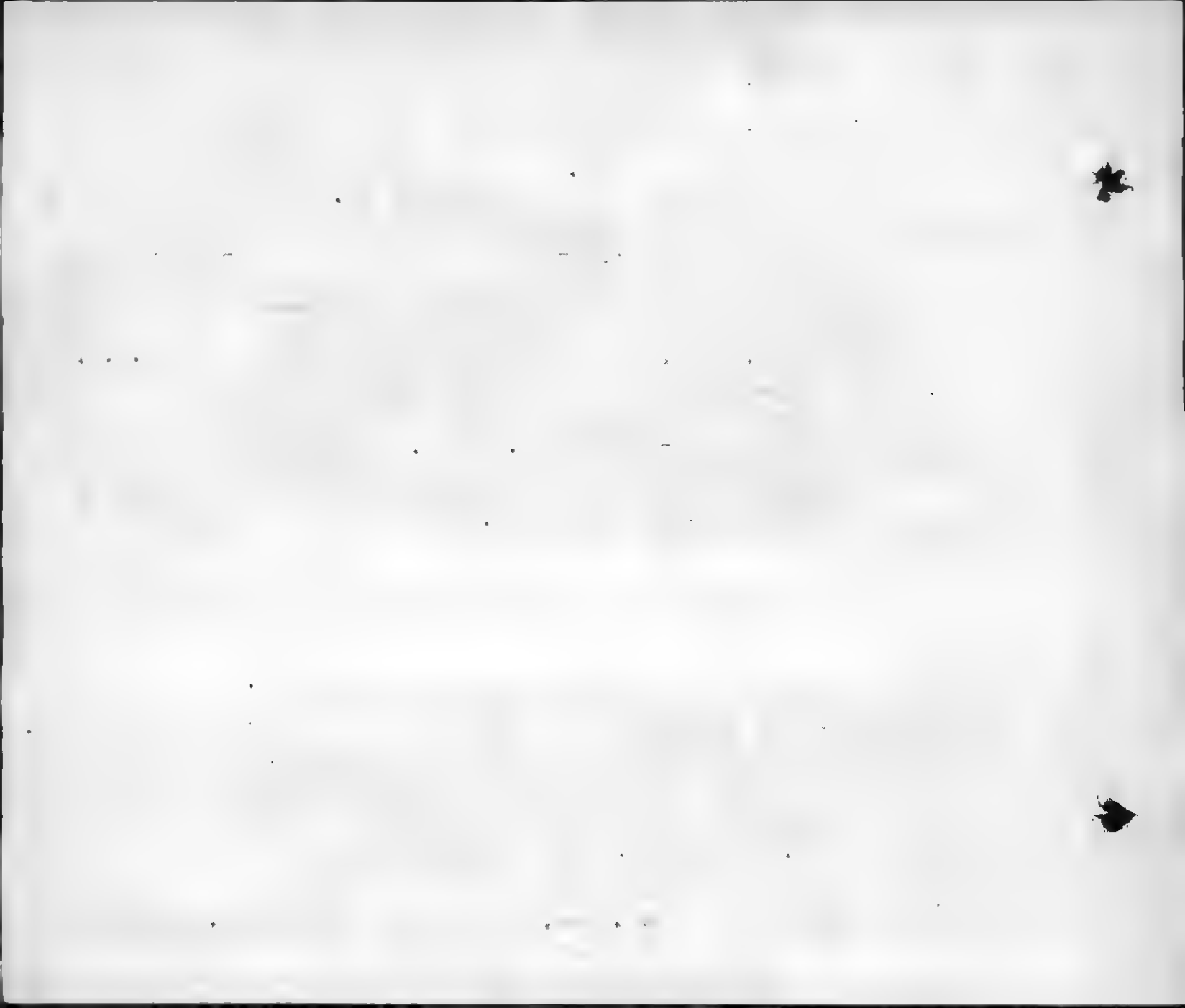
Reg. Dist. No.

10727

10730

| | | | |
|--|---------------------------|---|--|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> | |
| b. CITY OR TOWN (If outside of corporate limits, write RURAL, and give nearest town) <u>Salisbury</u> | | c. LENGTH OF STAY IN TB <u>2 hrs.</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u> | | e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> f. STREET ADDRESS <u>1409 Mount St.</u> | |
| 3. NAME OF DECEASED (Type or print) <u>Henry Thomas Stephens</u> | | 4. DATE OF DEATH Month <u>9</u> Day <u>6</u> Year <u>1958</u> | |
| 5. SEX <u>M</u> | 6. COLOR OF RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>April 30, 1929</u> 29 yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Police officer.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Sal. City Police</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>North Carolina</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James Clayton Stephens</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO <u>238-36-6573</u> | |
| 17. INFORMANT <u>Mrs. Ann E. Stephens</u> | | Address <u>Same</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhage due to bullet wound of right</u> <u>sub-clavian artery.</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18) <u>Shot in neck while making an arrest.</u> | |
| 20c. TIME OF INJURY Month, Day, Year <u>9-6-58</u> | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Street</u> | | 20f. (City or town) <u>Salisbury</u> (County) <u>Wicomico</u> (State) <u>MD.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE <u>Earl L. Royer</u> M.D. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | |
| EXAMINER'S NAME (Type) <u>Earl L. Royer</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9/10/1958</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>Wico. Mem. Park</u> | | 22d. LOCATION (City, town, or county) <u>Salisbury, Maryland</u> (State) _____ | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. Salisbury, Md.</u> | | 24a. REC'D BY REGISTRAR <u>SEP 15 '58</u> | |
| | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hays</u> | |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
10731
CERTIFICATE OF DEATH

10728

Reg. Dist. No.

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>WORCESTER</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | c. LENGTH OF STAY IN 1b <u>26 DAYS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Peninsula General Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Laura R. Stevenson</u> | | 4. DATE OF DEATH Month Day Year <u>September 14-19 58</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JAN. 11, 1884</u> |
| 9. AGE (In years last birthday) <u>74</u> yrs | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | 11. BIRTHPLACE (State or foreign country) <u>VIRGINIA</u> | 12. CITIZEN OF WHAT COUNTRY? <u>USA.</u> |
| 13. FATHER'S NAME <u>WILLIAM G. RUDASILL</u> | | 14. MOTHER'S MAIDEN NAME <u>LOUISE PRIEST</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>NO.</u> | | 16. SOCIAL SECURITY NO <u>NONE</u> | |
| 17. INFORMANT <u>JAMES W. STEVENSON, COLLEGE PARK, MD.</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Kerionitis, generalized</u> DUE TO <u>2 10/5</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Ulcerum, gangrenous</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cardiac failure, arteriosclerotic C.V.D.</u> | | INTERVAL BETWEEN ONSET AND DEATH <u>28 days</u> <u>58 days</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Aug 19, 1958</u> to <u>Sept 14, 1958</u> , that I last saw the deceased alive on <u>Sept 14, 1958</u> , and that death occurred at <u>6:48 PM</u> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>William B. Long</u> M.D. | | DATE SIGNED <u>Medical Center, Salisbury, Md.</u> | |
| PHYSICIAN'S NAME (Type) <u>WILLIAM B. LONG</u> | | <u>SALISBURY, MARYLAND</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 22b. DATE THEREOF <u>9-16-58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>PRESBYTERIAN CEMETERY</u> | |
| 22d. LOCATION (City, town, or county) (State) <u>Pocomoke City, Maryland</u> | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Henry A. Watson</u> | | 24a. REC'D BY REGISTRAR <u>SEP 17 '58</u> | |
| ADDRESS <u>Pocomoke City, MD.</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u> | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



BALTIMORE STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

10732

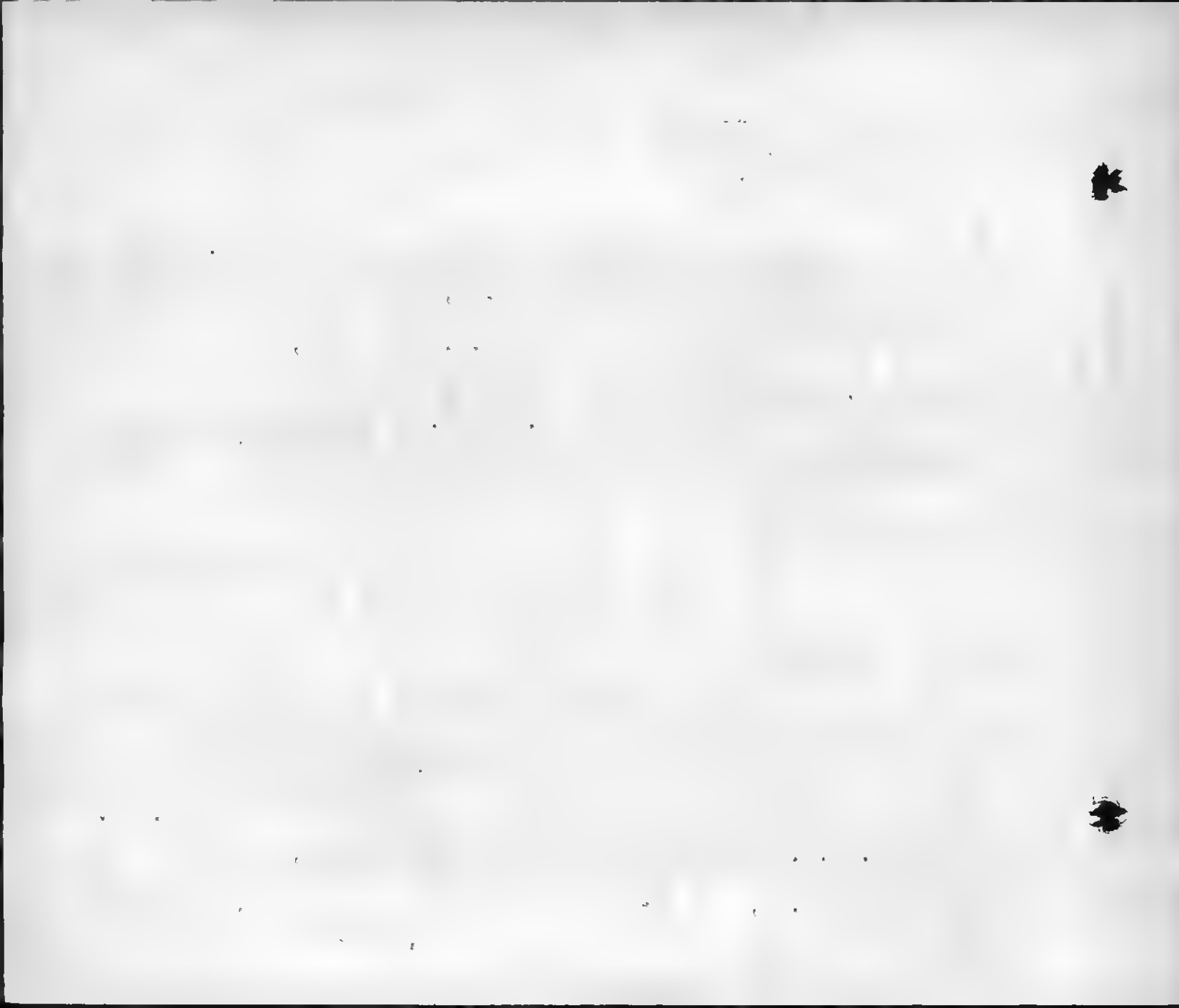
CERTIFICATE OF DEATH

Reg. Dist. No.

10730

| | | | | | | | |
|--|---|---|--|---|--|--|---|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Pemberton Road | | | | d. STREET ADDRESS Pemberton Road | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First LILLIE Middle ESTHER Last TWILLEY | | | | 4. DATE OF DEATH Month SEPT. Day 19th Year 1958 | | | |
| 5. SEX Female | 6. COLOR OR RACE White | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 20, 1874 | | 9. AGE (In years last birthday) 84 yrs | 10. IF UNDER 1 YEAR Months 6 Days 29 Hours Min. | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) House Work at Home | | 10b. KIND OF BUSINESS OR INDUSTRY None | | 11. BIRTHPLACE (State or foreign country) R.D. Salisbury, Md | | 12. CITIZEN OF WHAT COUNTRY? U S A | |
| 13. FATHER'S NAME Benjamin H. Hearn | | | | 14. MOTHER'S MAIDEN NAME Mary Ellen Hearn | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO | | 17. INFORMANT Mrs. Ruth T. Hearn (Daughter) Pemberton Drive - Salisbury, Maryland | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) arteriosclerotic heart disease 420.0 DUE TO congestive failure Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH 6-7 yrs |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Delirium | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I attended the deceased from 1953 to Sept. 17, 1958 , that I last saw the deceased alive on Sept. 18, 1958 , and that death occurred at 11:30 A.M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Sept. 21, 1958 | | | | | | | |
| ACTUAL SIGNATURE Act. Sohler | | M.D. | | | | | |
| PHYSICIAN'S NAME (Type) Dr. L.V. Sohler | | 303 East Delmar, Maryland | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF Sept. 21, 1958 | 22c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | | 22d. LOCATION (City, town, or county) (State) Salisbury, Maryland | | | |
| 23. FUNERAL DIRECTOR'S SIGNATURE HOLLOWAY & COMPANY SALISBURY MARYLAND | | | | 24a. REC'D BY REGISTRAR DATE SEP 23 '58 | | 24b. REGISTRAR'S SIGNATURE William E. Hearn | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director. page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 will be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10733

CERTIFICATE OF DEATH

10731

Reg. Dist. No.

| | | | |
|---|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>WORCESTER</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> | | c. LENGTH OF STAY IN TB <u>23 DAYS</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u> | | d. STREET ADDRESS <u>116 W. FEDERAL ST.</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>JAMES</u> Middle <u>WALKER</u> Last <u>WALKER</u> | | 4. DATE OF DEATH Month <u>SEPTEMBER</u> Day <u>7</u> Year <u>1958</u> | |
| 5. SEX <u>MALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>MAR. 25, 1888</u> |
| 9. AGE (In years last birthday) <u>70</u> yrs | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>WAYMASTER WESTERN MD. R.R.</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OREGON</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>WILLIAM B. WALKER</u> | | 14. MOTHER'S MAIDEN NAME <u>ALICE DONALDSON</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>YES</u> | | 16. SOCIAL SECURITY NO. <u>MRS. VERA HUTTON CATONSVILLE, MD</u> | |
| 17. INFORMANT <u>MRS. VERA HUTTON</u> | | Address <u>CATONSVILLE, MD</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYSENTAIC THROMBOSIS</u> <u>510.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ | | INTERVAL BETWEEN ONSET AND DEATH <u>23 DAYS</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____ | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) _____ (County) _____ (State) _____ | |
| 21. I certify that I attended the deceased from <u>Aug 15, 1958</u> , to <u>9-7</u> , 1958, that I last saw the deceased alive on <u>Sept 7</u> , 1958, and that death occurred at <u>1:30 A.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>SEP 7, 1958</u> | | | |
| ACTUAL SIGNATURE <u>John M. Bloxom</u> M.D. | | PHYSICIAN'S NAME (Type) <u>Dr. John M. Bloxom</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>9/10/58</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY <u>LOUPON PARK</u> | | 22d. LOCATION (City, town, or county) (State) <u>BALTIMORE, MD.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Easton's Sons</u> ADDRESS <u>CATONSVILLE, MD</u> | | 24a. REC'D BY REGISTRAR <u>SEP 9 '58</u> | |
| 24b. REGISTRAR'S SIGNATURE <u>Charles E. Hume</u> | | | |



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10732

10734

Reg. Dist. No.

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained by the funeral director. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|--|---------------------------|--|--|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> <u>MARYLAND</u> | | | 2. USUAL RESIDENCE (Where deceased lived If institution, Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u> | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Nanticoke</u> | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Peninsula General Hospital</u> | | | d. STREET ADDRESS | | |
| 3. NAME OF DECEASED (Type or print) <u>Levin J. Walter</u> | | | 4. DATE OF DEATH <u>9-7-1958</u> | | |
| 5. SEX <u>M</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan. 27, 1888</u> | | 9. AGE (In years last birthday) <u>70 yrs</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Interman</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Oyster racker</u> | | 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | |
| 13. FATHER'S NAME <u>Levin Thomas Walter</u> | | 14. MOTHER'S MAIDEN NAME <u>Emily Susan Walter</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>No</u> | | 16. SOCIAL SECURITY NO | | 17. INFORMANT <u>Lynn Walter, Delmar Rd., Salisbury Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | | | | | |
| PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Crushed chest.</u> 816X DUE TO Conditions, if any, which gave rise to immediate cause (b) _____ (c), stating the underlying cause last. (c) _____ DUE TO | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) <u>Passenger in car involved in a collision.</u> | | | |
| 20c. TIME OF INJURY Month, Day, Year <u>6:40 a.m. 9-7-58</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Light</u> | |
| 20f. (City or town) <u>Selbyville</u> | | (County) _____ | | (State) <u>Del.</u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE <u>Earl L. Royer</u> | | M. D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | DATE SIGNED <u>9-9-58</u> | |
| EXAMINER'S NAME (Type) <u>Earl L. Royer, M.D.</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | |
| 22a. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>9/10/58</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Turner's Cem.</u> | |
| 22d. LOCATION (City, town, or county) <u>Nanticoke Md.</u> | | (State) _____ | | 24a. REC'D BY REGISTRAR <u>SEP 15 '58</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>C. D. Messick</u> | | ADDRESS <u>Bivalve, Maryland</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | |



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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, 18

SEP 23 1958

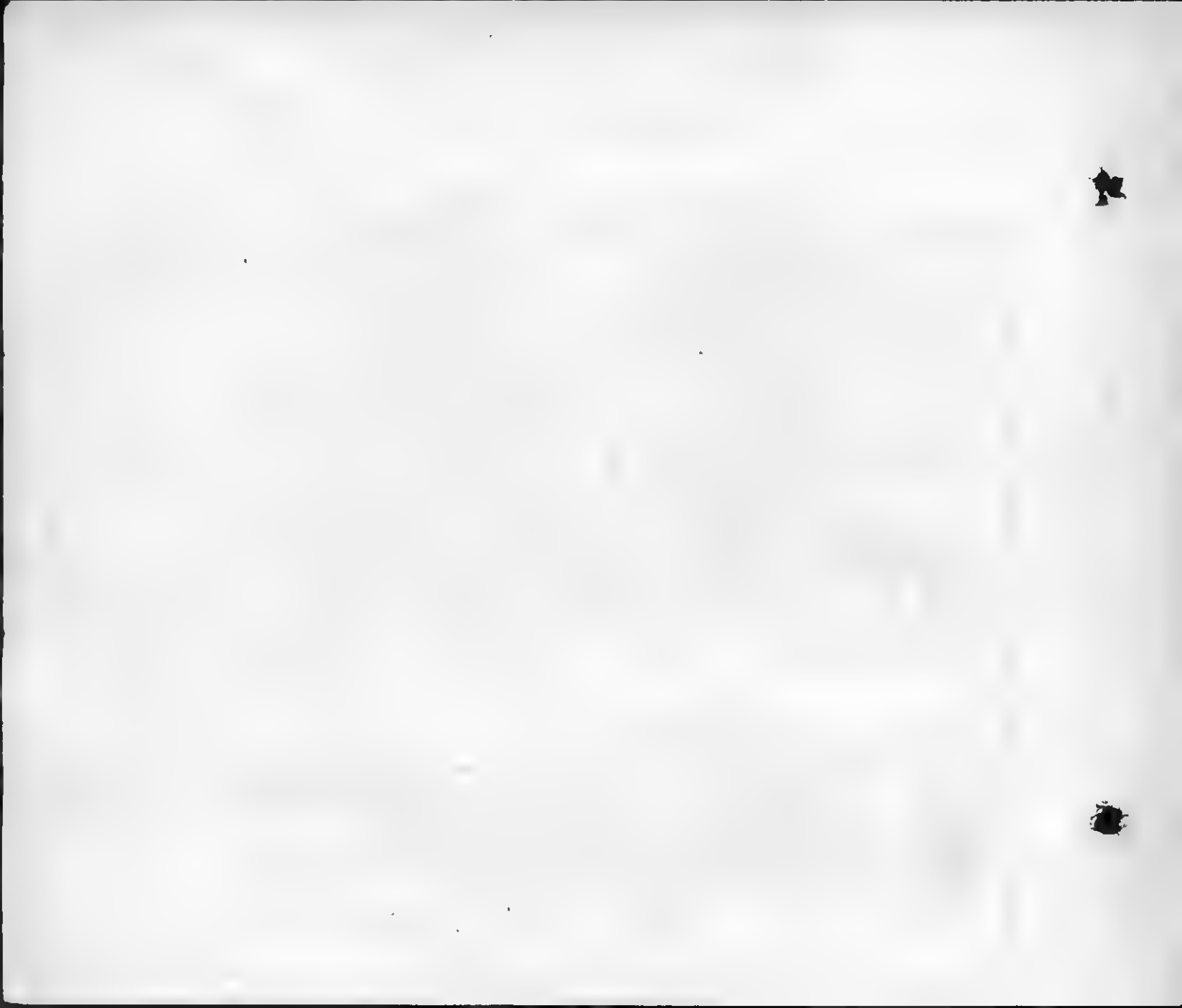
CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|-------------------------------------|---|---|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tyaskin</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. STREET ADDRESS <u>1</u> | |
| 3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>WHITE</u> Last <u>WHITE</u> | | 4. DATE OF DEATH Month <u>Sept.</u> Day <u>17</u> Year <u>19 58</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3/27/1878</u> |
| 9. AGE (In years last birthday) <u>80</u> yrs. | | 10. IF UNDER 1 YEAR Months <u>5</u> Days <u>20</u> Hours <u></u> Min. <u></u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Inspector</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Quarantine Station</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Maryland</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>Unknown</u> | | 14. MOTHER'S MAIDEN NAME <u>Charlotte Anne Evans</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO <u>-----</u> | |
| 17. INFORMANT <u>Mary Hearne, Tyaskin, Maryland</u> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Generalized Arteriosclerosis</u> DUE TO (c) <u></u> | | INTERVAL BETWEEN ONSET AND DEATH <u>10 days</u> <u>10 years</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18) | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>o. m</u> <u>19</u> p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>8 Sept. 1958</u> to <u>17 Sept. 1958</u> , that I last saw the deceased alive on <u>17 Sept. 1958</u> , and that death occurred at <u>4:30 p. m.</u> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE <u>Richard H. Saunders</u> | | DATE SIGNED <u>9/19/58</u> | |
| PHYSICIAN'S NAME (Type) <u>Richard H. Saunders</u> | | <u>Nanticoke, Maryland</u> | |
| 22a. BURIAL CREMATION, REMOVAL (Specify) <u>Burial</u> | 22b. DATE THEREOF <u>9/19/58</u> | 22c. NAME OF CEMETERY OR CREMATORY <u>Robertson Cem.</u> | 22d. LOCATION (City, town, or county) (State) <u>Tyaskin, Maryland</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>C. G. Messel</u> | | ADDRESS <u>Silvale, Maryland</u> | |
| 24a. REC'D BY REGISTRAR DATE <u>SEP 23 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>C. G. Messel</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

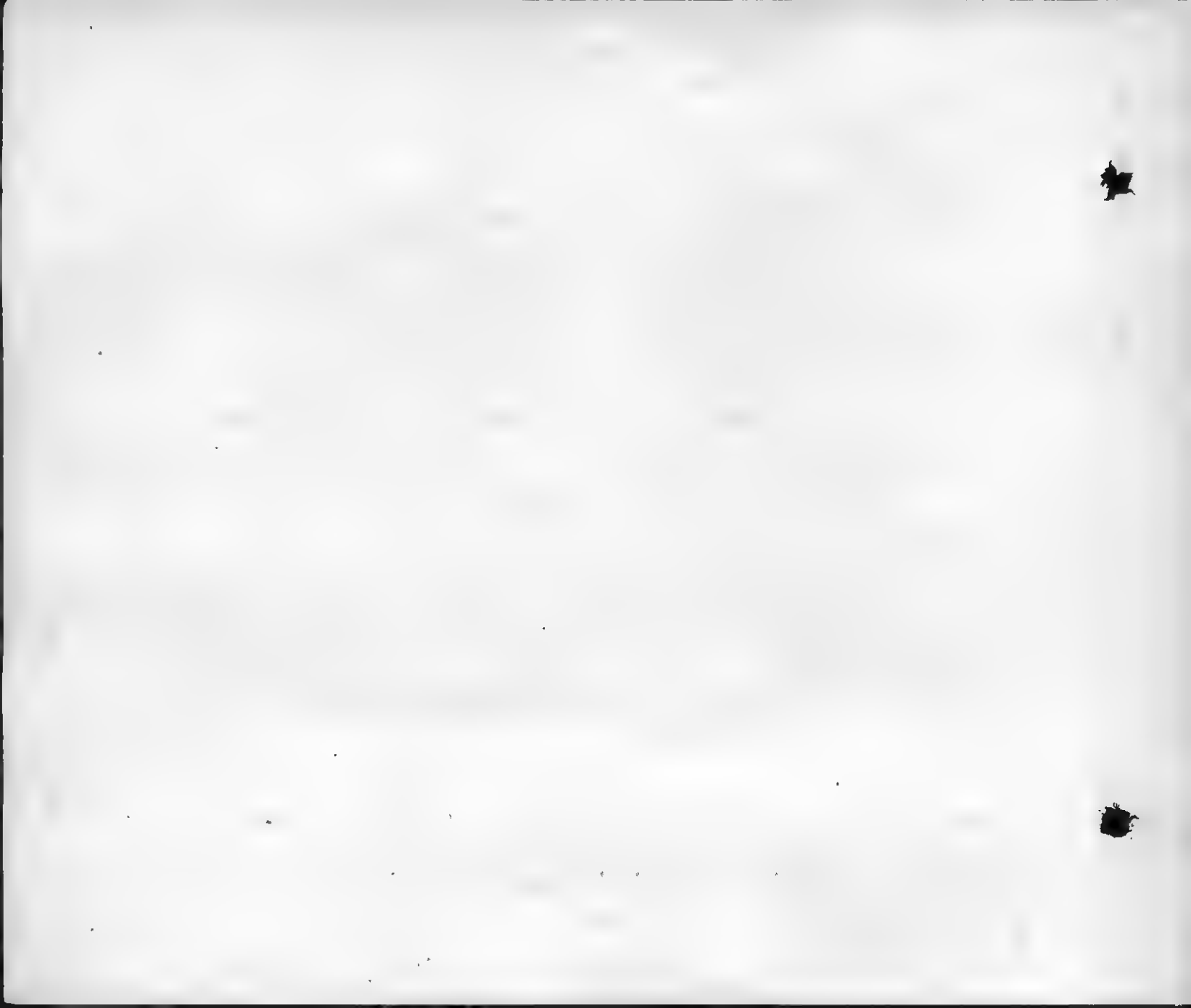
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CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | |
|--|----------------------------------|--|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission) a. STATE Maryland b. COUNTY Baltimore | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Salisbury | | c. LENGTH OF STAY IN 1b 4 mos. 3 days | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Deer's Head State Hospital | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Ethel Middle Corzellor Last Whye | | 4. DATE OF DEATH Month September Day 17 Year 19 58 | |
| 5. SEX Female | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH January 20, 1895 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY | 9. AGE (In years last birthday) 63 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min |
| 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME Clinton Whye | | 14. MOTHER'S MAIDEN NAME Susanna Martin | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no, or unknown) (If yes, give war or dates of service) Unk | | 16. SOCIAL SECURITY NO 214 22 I 791 | |
| 17. INFORMANT Address Hospital Records, Salisbury, Maryland | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] | |
| PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Multiple Sclerosis | | INTERVAL BETWEEN ONSET AND DEATH 5 years | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Arteriosclerotic Cardiovascular Disease | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of stem 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While at work Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from May 14 , 19 58 , to September 17 , 19 58 , that I last saw the deceased alive on September 17 , 19 58 , and that death occurred at 2:00 P. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE V. Juerman M. D. | | ADDRESS (Street, city or town, state) Deer's Head State Hospital DATE SIGNED 9/17/58 | |
| PHYSICIAN'S NAME (Type) V. Juerman, M. D. | | Salisbury, Maryland | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 22b. DATE THEREOF 9/21/58 | 22c. NAME OF CEMETERY OR CREMATORY St. Lukes | 22d. LOCATION (City, town, or county) (State) Hereford Balto. Co. Md. |
| 23. FUNERAL DIRECTOR'S SIGNATURE W. I. Chatman, Jr. ADDRESS 1701 McCulloh St. Balto. Md. | | 24a. REC'D BY REGISTRAR SEP 22 '58 | 24b. REGISTRAR'S SIGNATURE Arthur S. Hanna |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10735

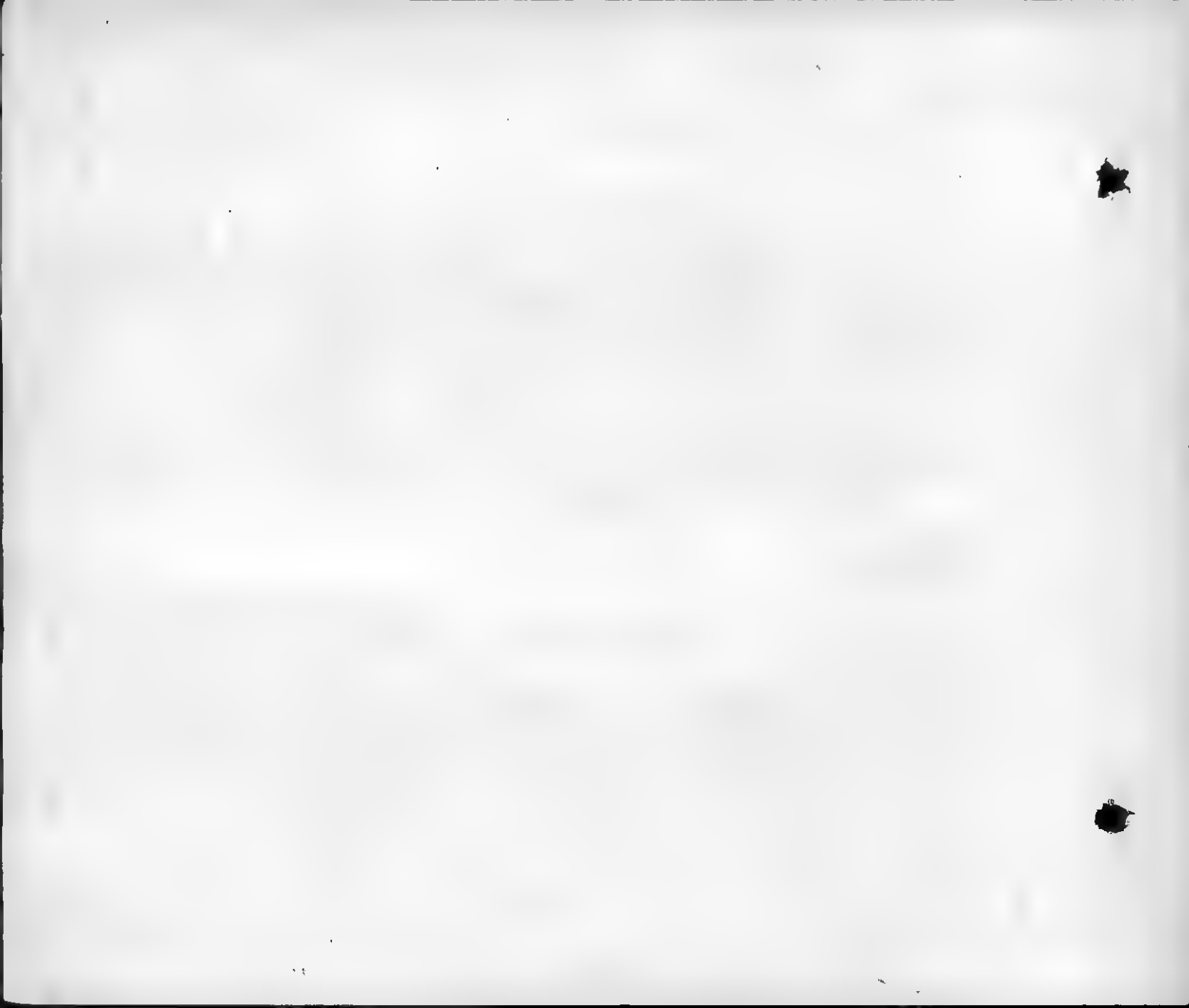
Item 18 Film 234 10-6-58 amb

CERTIFICATE OF DEATH

Item 8, Film G-270736 10/58.cac

Reg. Dist. No.

| | | | |
|---|---|---|---|
| 1. PLACE OF DEATH a. COUNTY WICOMICO | | 2. USUAL RESIDENCE (Where deceased lived If institution Residence before adm'ssion) a. STATE MARYLAND b. COUNTY WORCESTER | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SALISBURY | | c. LENGTH OF STAY IN TB 23X-2 | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION PENINSULA GENERAL HOSPITAL | | d. STREET ADDRESS WILLIAMS ST. | |
| 3. NAME OF DECEASED (Type or print) CLARA McCABE WIMBROUGH | | 4. DATE OF DEATH Month SEPTEMBER Day 20 Year 1958 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH April 9, 1908 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE | | 10b. KIND OF BUSINESS OR INDUSTRY OWN HOME | 9. AGE (In years last birthday) 50 yrs |
| 11. BIRTHPLACE (State or foreign country) LEXANA, DEL. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A | |
| 13. FATHER'S NAME J. PORT McCABE | | 14. MOTHER'S MAIDEN NAME MAZELLA HICKMAN | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service) NO | | 16. SOCIAL SECURITY NO NO | |
| 17. INFORMANT MR. C.B. WIMBROUGH | | Address Berlin Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Meningococcal Meningitis 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pneumococcal pneumonia DUE TO (c) PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 12 hours | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from 9-19 , 1958, to 9-20 , 1958, that I last saw the deceased alive on 9-20 , 1958, and that death occurred at 3:47 P.M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE William A. Ellis Jr. | | ADDRESS (Street, city or town, state) Salisbury, Md. | |
| PHYSICIAN'S NAME (Type) William A. Ellis Jr. | | DATE SIGNED 9-20-58 | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 22b. DATE THEREOF 9/22/58 | 22c. NAME OF CEMETERY OR CREMATORY EVERGREEN | 22d. LOCATION (City, town, or county) (State) BERLIN MD |
| 23. FUNERAL DIRECTOR'S SIGNATURE James A. Buehler | | 24a. REC'D BY REGISTRAR SEP 23 58 | |
| ADDRESS Berlin Md | | 24b. REGISTRAR'S SIGNATURE Arthur L. Knaus | |



10737

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|---|---|--|---|
| 1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY</u> | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>12 SALISBURY</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>PENINSULA GENERAL HOSPITAL</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>MINNIE NELSON WINDSOR</u> | | | | 4. DATE OF DEATH Month Day Year <u>SEPTEMBER 15 1958</u> | | | |
| 5. SEX <u>FEMALE</u> | 6. COLOR OR RACE <u>WHITE</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>JULY 17, 1880</u> | 9. AGE (In years last birthday) <u>78</u> yrs. | IF UNDER 1 YEAR Months Days Hours Min. | | IF UNDER 24 HRS. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>OWN HOME</u> | | 11. BIRTHPLACE (State or foreign country) <u>DELAWARE</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>John NELSON</u> | | | | 14. MOTHER'S MAIDEN NAME <u>CARRIE BLESSING</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> | | 16. SOCIAL SECURITY NO. <u>NONE</u> | | 17. INFORMANT Name Address <u>Walter D. Windsor - SAME</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertensive Cardiovascular Disease</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Carcinoma of the breast. Coronary Artery Sclerosis</u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | 20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m. | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) | | (County) | | (State) | |
| 21. I certify that I attended the deceased from <u>Sept. 14, 1958</u> to <u>Sept. 15, 1958</u> , that I last saw the deceased alive on <u>Sept. 14, 1958</u> , and that death occurred at <u>12:24 AM</u> , from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>David J. Gilmore</u> M.D. | | | | DATE SIGNED <u>Salisbury Md. Sept. 15, 1958</u> | | | |
| PHYSICIAN'S NAME (Type) <u>DAVID J. GILMORE MEDICAL CENTER SALISBURY, MD.</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>9/17/1958</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>PARSONS CEMETERY</u> | | 22d. LOCATION (City, town, or county) (State) <u>SALISBURY, MARYLAND</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>Hill & Johnson Co. SALISBURY, MD.</u> | | | | 24a. REC'D BY REGISTRAR DATE <u>SEP 17 '58</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. House</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

10121

RECEIVED



10745

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|------------------------------------|---|-------------------------------------|---|--|---|--|
| 1. PLACE OF DEATH a. COUNTY Wicomico MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Wicomico | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jesterville | | | | c. LENGTH OF STAY IN Tb Lifetime | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First STEWART Middle W. Last WRIGHT | | | | 4. DATE OF DEATH Month Sept. Day 10 Year 19 58 | | | |
| 5. SEX Male | 6. COLOR OR RACE Colored | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH 5/4/1881 | 9. AGE (In years last birthday) 77 yrs. | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months 4 Days 6 Hours Min. | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Waterman | | 10b. KIND OF BUSINESS OR INDUSTRY Oyster tonger | | 11. BIRTHPLACE (State or foreign country) Maryland | | 12. CITIZEN OF WHAT COUNTRY? U.S. | |
| 13. FATHER'S NAME Stewart Wright | | | | 14. MOTHER'S MAIDEN NAME Unknown | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No | | 16. SOCIAL SECURITY NO. 217-28-5840 | | 17. INFORMANT Mollie Anderson, Jesterville, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 177X Premia DUE TO Carcinoma prostate Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) | | | | | | INTERVAL BETWEEN ONSET AND DEATH 10 days 3 m + | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19 | | 20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 10 June 1958 to 16 Sept. 1958 , that I last saw the deceased alive on 11 Sept. 1958 , and that death occurred at 12:30 M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE E. A. Purcell M.D. | | | | ADDRESS (Street, city or town, state) 652 W. Main St., Md. | | | |
| PHYSICIAN'S NAME (Type) E. A. Purcell, M.D. Salisbury, Md. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF 9/14/58 | | 22c. NAME OF CEMETERY OR CREMATORY Jesterville Cem. | | 22d. LOCATION (City, town, or county) (State) Jesterville, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE C. J. Mesant ADDRESS Bivalve, Maryland | | | | 24a. REC'D BY REGISTRAR DATE SEP 16 '58 | | 24b. REGISTRAR'S SIGNATURE Arthur S. Knorr | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

